

**State of Indiana
Statewide Comprehensive Plan
including the
Statewide Coordinated Statement of Need**

**FY 2009 – 2010
FY 2010 – 2011
FY 2011 – 2012**

**Prepared for the
Health Resources and Services Administration
by the
Indiana State Department of Health**

January 2009

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LETTER OF CONCURRENCE

Brian Fisher
6102 N. Michigan Rd.
Indianapolis, IN 46228

10 November 2008

Shawn Carney
Ryan White Part B Director and HIV Services Coordinator
Division of HIV/STD
Indiana State Department of Health
2 N. Meridian St., Section 6-C
Indianapolis, IN 46204

Mr. Carney-

After close collaboration and careful review, the Executive Board of the Comprehensive HIV Services Planning and Advisory Council is pleased to offer our concurrence with the Division of HIV/STD's Statewide Comprehensive Plan for Fiscal Year 2009-2010.

Please let us know if we may be of any further assistance. The council looks forward to working together with you in the coming year.

Sincerely,

A handwritten signature in dark ink, appearing to read "Brian Fisher", is written over a light gray background.

Brian Fisher
Comprehensive HIV Services Planning and Advisory Council, Chair

CONTRIBUTORS

The Indiana State Department of Health, Division of HIV/STD, gratefully acknowledges the following individuals who contributed their time and expertise to develop and complete this Statewide Comprehensive Plan.

Part A

- Catherine Lesko, Epidemiologist, Health and Hospital Corporation of Marion County/Marion County Health Department
- Michael Wallace, Ryan White Part A Director, Health and Hospital Corporation of Marion County/Marion County Health Department

Part B

- Neal Carnes, HIV Medical Services Program Manager, Division of HIV/STD, Indiana State Department of Health
- Shawn Carney, Ryan White Part B Director/HIV Services Coordinator, Division of HIV/STD, Indiana State Department of Health
- Darin Foltz, Special Populations Support Program Manager, Division of HIV/STD, Indiana State Department of Health
- Telisa Lloyd, HIV Services Advisory Board Liaison, Division of HIV/STD, Indiana State Department of Health
- Kristi Montgomery, HIV Care Coordination Program Manager, Division of HIV/STD, Indiana State Department of Health

Part C

- Portia L. Duff, Ryan White Part C Program Director, Health and Hospital Corporation of Marion County/Marion County Health Department
- Brenda Kreiger, RN, Part C Adherence Specialist, Matthew 25 AIDS Services
- Yvette Paniagua, Part C Benefits Coordinator, East Chicago Community Health Center

Part F

- Malinda Boehler, Director of the Midwest AIDS Training and Education Center, Clarian Health

Community Members

- Tom Beatty, Director of Client Services, AIDS Ministries/AIDS Assist
- Katie Bennett, HIV Care Coordinator, Meridian Services Corporation
- Jamie Crabb, HIV Care Coordinator, Clark County Health Department
- Brian Fisher, Comprehensive HIV Services Planning and Advisory Council chair
- Tony Gillespie, Executive Director, Brothers Uplifting Brothers
- Tracy Huck, HIV Care Coordinator, AIDS Resource Group
- Kelly Thompson, HIV Care Coordinator, Wishard Health Services
- Teresa White, Program Manager, The Bethlehem House

INTRODUCTION

Purpose

The Statewide Comprehensive Plan is a thorough description of the HIV service delivery system as implemented in Indiana. The plan documents the state's Ryan White HIV/AIDS Treatment Modernization Act (hereinafter referred to as the Ryan White Program) Part B funding allocation rationale, its efforts to provide services to those not currently receiving care, its collaborations with other service providers, and its goals and objectives for the maintenance and improvement of the system of care. The plan fully incorporates Indiana's Statewide Coordinated Statement of Need.

Process

In response to the legislative mandates of the Ryan White Program, the Division of HIV/STD (hereinafter referred to as the Division) at the Indiana State Department of Health (ISDH) regularly revises its HIV service delivery plan based on the changing demands of the epidemic. The current plan was prepared by the Division based on utilization trends and various surveys conducted in FY2007-2008 and FY2008-2009. The Planning Committee of the Comprehensive HIV Services Planning and Advisory Council (CHSPAC) – comprised of Ryan White Parts A, B, C, and F grantees, service providers, persons living with HIV, and other community members – reviewed the document in draft form and conducted a series of five meetings to update the appropriate sections.

1. The Planning Committee reviewed the latest draft, made initial editing suggestions, established a timeline, and agreed on work assignments.
2. The Planning Committee conducted two separate open meetings for consumers and providers not affiliated with CHSPAC to comment on the plan as written and to voice additional concerns about the HIV service delivery system.
3. The Planning Committee agreed reviewed the proposed changes to the narrative sections, began updating the goals and objectives, and agreed on additional work assignments. The committee also solicited feedback from the full advisory council at this point.
4. The Planning Committee conducted a conference call without the participation of ISDH in order to allow members to discuss the plan without any overt direction from ISDH. Previously unvoiced perspectives were discussed and additional suggestions were forwarded to ISDH following the call.
5. The Planning Committee conducted a final meeting to review all changes and final edits. The final draft was later prepared by ISDH and submitted to the Executive Committee for a letter of agreement.

The final draft subsequently received approval from the Executive Committee for submission to the Health Resources and Services Administration (HRSA).

EXECUTIVE SUMMARY

Indiana is primarily a rural state reporting 702 new and 8851 living cases of HIV disease in 2007. Nearly 55% of the living cases have had an AIDS diagnosis. The largest proportion of cases continues to be White males over the age of 40, though Blacks are still more disproportionately affected by the disease than any other demographic group. In a year with decreasing total case reports, women experienced a 16% increase in new reports, and new cases for Hispanics increased by 9%.

Indiana's various instruments to assess the needs of people with HIV have yielded results which affirm the importance of the six core service areas originally defined by HRSA. In addition to Primary Medical Care, HIV-related Medications, Oral Health, Case Management, Mental Health Treatment, and Substance Abuse Treatment, the Division has added Transportation and Housing to describe its priority service needs.

Of the 8851 persons living with HIV, the Division has estimated that 3544 are not currently in care. The current continuum of care is designed to address this population by minimizing barriers and optimizing access to HIV-related medical and social services. The resources of the state's Ryan White Program grantees and other providers have been coordinated in an attempt to impact each of the priority service needs in an effective and efficient manner.

Indiana is the proud home of four Ryan White grants representing Parts A, B, and C (formerly Titles I, II, and III). In general, Part A provides emergency assistance to Eligible Metropolitan Areas and Transitional Grant Areas that are most severely affected by the HIV epidemic. Part B provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five U.S. Pacific Territories or Associated Jurisdictions. Part B grants include a base grant, the AIDS Drug Assistance Program (ADAP) award, ADAP Supplemental grants and grants to States for Emerging Communities. Part C provides grants directly to service providers such as ambulatory medical clinics to support outpatient HIV early intervention services and ambulatory care. Part C also funds planning grants, which support organizations in more effectively delivering HIV care and services and capacity development grants to enhance a grantee's capacity to develop, strengthen, or expand access to high quality HIV primary health care services for people living with HIV or who are at risk of infection in underserved or rural communities and communities of color.

Part F of the Ryan White Program also is represented in Indiana. Part F provides support for the AIDS Education and Training Centers Program which is a network of regional and national centers that train health care providers to treat persons with HIV. As the clinical training component of the Ryan White Program, these centers seek to improve health outcomes of people living with HIV through training on clinical management of HIV disease in such areas as use of antiretroviral therapies and prevention of HIV transmission. The program targets providers who treat minority, underserved, and vulnerable populations in communities most affected by the HIV epidemic.

But despite the coordinated efforts of the Ryan White Program grantees and other providers, challenges remain for the state, including the current waiting list for statewide Part B medical services. To address them, Indiana has compiled a number of suggestions for service delivery improvement. Many of these are incorporated into its goals and objectives for 2009-2012. Evaluation of the progress towards these goals – and of the continuum of care itself – will be accomplished through the monitoring efforts of the Ryan White Program grantees and the Division's advisory council.

Section 1, Part 1 – STATEWIDE COORDINATED STATEMENT OF NEED

Overview

As a component of each edition of the Comprehensive Plan, the Division develops an updated version of its Statewide Coordinated Statement of Need (SCSN). The SCSN is a general statement of the needs of persons living with HIV in the State of Indiana. It seeks to describe the epidemiological trends, service history, needs assessments, priority service areas, gaps in and barriers to care for the affected population, and prevention needs for the State.

Description of State

Indiana is a mostly rural state with several urban and metropolitan centers; it has an estimated population of 6,313,520 people, based on Census Bureau projections for 2006. The majority of the population is White. The largest minority group is Black, followed by persons who identify as Hispanic. The remainder of the population is comprised of Asian-Americans, American Indians and Alaska Natives, and Pacific Islanders.

Epidemiological Profile

Indiana's surveillance data are derived from the HIV and AIDS reports submitted by providers and laboratories to Indiana's Office of Clinical Data and Research (OCDR). Prevalence data do not include those cases known to have moved from the state or to have died. The information that follows is a brief overview of the state's significant epidemiology. (A complete epidemiological profile for HIV disease in the State of Indiana is available upon request.)

Between 1999 and 2002, the reporting of new cases of HIV disease had increased each year (including both in-state and out-of-state reports submitted to Indiana). In 2003 and 2004, this trend reversed, and the number of new cases decreased drastically. At the time, the OCDR proposed that the reduction of new cases was due to the conclusion of the intensified surveillance activities of 2002.

As expected, the decline did not continue in 2005. In that year, the number of new cases nearly returned to the levels seen in 2003, indicating that 2002 and 2004 may have been the anomalies with abnormally high and low new case reports respectively. In hindsight, an argument can be made for a natural, steady increase in new cases from 1999 to 2001 (609, 639, 710), a plateau in 2003 (702), and a continuation of the increase in 2005 (734). By 2006, another relative plateau (722) had been reached, and this appears to have continued through 2007 (702).

Table A. New Case Reports by Year 1999-2007

New Cases by Year	HIV		AIDS		Total Disease	
	#	Total ?	#	Total ?	#	Total ?
1999	300	--	309	--	609	--
2000	320	+ 7%	319	+ 3%	639	+ 5%
2001	421	+ 32%	289	- 9%	710	+ 11%
2002	531	+ 26%	372	+ 29%	903	+ 27%
2003	399	- 25%	303	- 19%	702	- 22%
2004	347	- 13%	252	- 17%	599	- 15%
2005	339	- 2 %	395	+ 57%	734	+ 23%
2006	382	+ 13%	340	- 14%	722	- 2%
2007	374	- 2%	328	- 4%	702	- 3%

In fact, between 2006 and 2007, the combined number of new positive tests actually declined by 3%. The table above shows the number of new reports received each year, beginning in 1999. The percent of change (?) in each category total compared to the preceding year is also presented in the table. As evidenced in Table A, an important difference existed between the rates of change for new HIV and AIDS cases in 2005 and 2006. Moreover, the trend itself appeared to be experiencing a wave of disruption. In 2005, HIV cases decreased modestly, and AIDS cases spiked; in 2006, the number of new cases of HIV showed a substantial reversal (increasing by 13%) while new AIDS case reports declined in nearly equal measure (14%). This phenomena, however, does not appear to have persisted in 2007, the first year since 2004 to show both HIV and AIDS cases decreasing by similar percentages. The Division's prevention staff and OCDR are studying the data to ascertain if adjustments in HIV testing or reporting initiatives may have had any impact and if any additional adjustments are necessary.

Table B below shows total numbers and percentages by race and gender characteristics for new case reports within the last eight years. It also calculates the percent of change in each category total from one year to the next. Despite the sometimes erratic nature of the overall trend of new HIV and

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- Prevention Needs

AIDS cases, the demographic qualities of the new cases themselves have remained relatively consistent over the decade. The percentage of new male reports each year has tended to stay near 80%. The reports have fluctuated very little by race, staying between 48-55% for Whites, 35-42% for Blacks, and 5-9% for Hispanics. In 2007, of all reported cases, males represented 75%, Whites 49%, Blacks 40%, and Hispanics 7%. In this way, the demographic trends may be seen as stable while the health of the newly tested population remains less so.

Table B. New Case Report Demographics 2000-2007

New Cases by Race & Gender	White	Black	Hispanic	All Other Race Categories	Total		Total ?
					#	%	
2000							
Male	312	166	26	2	506	79	--
Female	47	77	7	2	133	21	--
Total	359	243	33	4	639	100	--
Race %	56	38	5	1	100		
Total ?	--	--	--	--			
2001							
Male	307	177	33	7	524	74	+ 4%
Female	80	95	9	2	186	26	+ 40%
Total	387	272	42	9	710	100	+ 11%
Race %	55	38	6	1	100		
Total ?	+ 8%	+ 12%	+ 20%	+ 125%			
2002							
Male	425	253	46	12	736	82	+ 40%
Female	67	87	9	4	167	18	- 10%
Total	492	340	55	16	903	100	+ 27%
Race %	54	38	6	2	100		
Total ?	+ 27%	+ 25%	+ 31%	+ 78%			
2003							
Male	302	202	45	3	552	79	- 25%
Female	57	83	7	3	150	21	- 10%
Total	359	285	52	6	702	100	- 22%
Race %	51	41	7	1	100		
Total ?	- 27%	- 16%	- 5%	- 63%			
2004							
Male	246	165	48	3	462	77	- 16%
Female	44	85	6	2	137	23	- 9%
Total	290	250	54	5	599	100	- 15%
Race %	48	42	9	1	100		
Total ?	- 19%	- 12%	+ 4%	+ 0%			
2005							
Male	351	184	43	12	590	80	+ 28%
Female	53	76	12	3	144	20	+ 5%
Total	404	260	55	15	734	100	+ 23%
Race %	55	35	8	2	100		
Total ?	+ 39%	+ 4%	+ 2%	+ 200%			
2006							
Male	329	187	43	11	570	79	- 3%
Female	51	81	13	7	152	21	+ 6%
Total	380	268	56	18	722	100	- 2%
Race %	53	37	8	2	100		
Total ?	- 6%	+ 3%	+ 2%	+ 20%			
2007							
Male	273	197	37	19	526	75	- 8%
Female	68	82	14	12	176	25	+ 16%
Total	341	279	51	31	702	100	- 3%
Race %	49	40	7	4	100		
Total ?	+ 0%	+ 4%	+ 9%	+ 72%			

Table C shows the basic demographic qualities of persons living with HIV in Indiana. The percent of change in each category percentage from the end of the previous report period is also displayed. The AIDS prevalence data presented in the table are based on the total number of AIDS diagnoses reported to the OCDR, less those known to

have moved from the state or to have died, as of 31 December 2007. Likewise, the HIV prevalence data are derived from reports submitted to the Division's OCDR. Also accurate as of 31 December 2007, these figures exclude those known to have progressed to an AIDS diagnosis, moved from the state, or died. For purposes of HIV services planning, decisions are made primarily on the basis of total living cases of HIV disease (HIV and AIDS reports). This combination provides the most accurate total number of known HIV-infected persons who may require HIV care and services.

Between 2003 and 2004, the total number of persons living with HIV disease in Indiana had increased by 7.4%. An unexpected decrease (10.8%) was then seen between 2004 and 2005. By the end of 2006, however, the number of living cases was reported to have rebounded, increasing by 20.2%. As of 31 December 2007, OCDR reported 8851 living cases of HIV disease in the state, compared to 8630 at the end of 2006 (an increase of less than 3%). OCDR proposes that the decrease in 2005 was primarily due to the substantial increase in recorded death records which resulted from that year's intensive National Death Index match initiative. Of those living in the state in 2006, OCDR has documented that nearly 55% had progressed to a diagnosis of AIDS.

Table C. Prevalence Demographics through 2007

Prevalence As of 12/31/07	% in pop	HIV			AIDS			Combined		
		#	%	% ?	#	%	% ?	#	%	% ?
Gender										
Male	49	3123	78	+ 0	4022	83	- 1	7145	81	+ 0
Female	51	902	22	+ 0	804	17	+ 1	1706	19	+ 0
Total	100	4025	100		4826	100		8851	100	
Race										
White	86	2245	56	- 1	2782	58	- 1	5027	57	- 1
Black	8	1456	36	+ 1	1599	33	+ 1	3055	35	+ 1
Hispanic	4	233	6	+ 0	348	7	+ 0	581	6	+ 0
Other	2	91	2	+ 0	97	2	+ 0	188	2	+ 0
Total	100	4025	100		4826	100		8851	100	
Age										
0-19	29	51	1	- 1	29	1	- 1	80	1	- 1
20-29	14	571	14	+ 1	218	4	+ 0	789	9	+ 1
30-39	15	1118	28	- 1	1051	22	+ 0	2169	24	- 1
40-49	15	1480	37	+ 0	2220	46	+ 0	3700	42	+ 0
Over 49	27	805	20	+ 1	1308	27	+ 1	2113	24	+ 1
Total	100	4025	100		4826	100		8851	100	
Transmission										
MSM	--	1904	47	+ 0	2469	51	+ 0	4373	49	+ 0
IDU	--	142	4	+ 0	275	6	+ 0	417	5	+ 0
Heterosexual	--	728	18	+ 0	776	16	+ 0	1504	17	+ 0
Perinatal	--	45	1	+ 0	33	1	+ 0	78	1	+ 0
Other/No Risk	--	1206	30	+ 0	1273	26	+ 0	2479	28	+ 0
Total	--	4025	100		4826	100		8851	100	

The information in Table C shows that the vast majority of living cases of HIV disease (81%) in Indiana are men. The increases in the percentages of women and the decreases in the percentages of men which had been seen early in the decade were not repeated in either 2006 or 2007. In fact, this trend essentially reached a plateau after 2003. In 2007, Whites continued to be the most infected racial group. Compared to their presence in the population at large,

Blacks were still the most disproportionately affected. The overall distribution of disease among racial categories did not change significantly compared to 2004, 2005, or 2006.

The largest risk group continued to be composed of men who have sex with men. The exact size of this and the injection drug use risk groups remain in question, however, due to the inflated number reported in the "Other/No Known Risk" category. (The unusually frequent use of the unidentified risk category has been attributed to deficient data collection methods employed by HIV counseling and testing staff in the field, and this concern is receiving continued attention by OCDR.) The disease concentration in the 30-39 age bracket continued to weaken while the 50-plus bracket experienced sustained growth. For male youth, the greatest risk of exposure was homosexual contact; for women of all ages, it was heterosexual contact. Infection due to the use of injection drugs – to the extent it had been accurately measured given the concern noted above – appeared to stabilize among all groups.

Overall, this epidemiological data reinforce some familiar trends. First, the rate of new infections among women remains excessively high. In 2007, women experienced an overall increase of 16% compared to 2006 while the number of new cases among men decreased by 8%. Second, regardless of gender, Blacks continue to be the most disproportionately represented in the data. Blacks account for 36% of the living cases of HIV and 33% of the living cases of AIDS, yet they comprise only 8% of the general population.

Third, the 2007 data show that, for the third year in a row, two-thirds of the prevalence population is over the age of 40. The aging of the infected community has been recognized for a number of years; however, the continuation of the trend to this extreme carries equally positive and negative implications for the care and prevention providers, respectively.

In addition to anticipating that the current trends will continue, OCDR expects that, with the availability of effective treatments, the actual annual rate of death will maintain its downward trend. Coupled with new reports, this will result in further increases in the state's overall HIV disease prevalence and a greater demand for HIV-specific services.

Brief History of Service Response to HIV in Indiana

The first specific reference to AIDS in the Indiana State Code appeared in 1986 when the state required physicians and hospitals to report confirmed cases of AIDS to ISDH. The state's first service component was the HIV Care Coordination Program which was the end result of recommendations made by the HIV/AIDS Health and Human Services Planning Project for Indiana conducted during 1989 and 1990. It was determined in the planning process that "care coordination services are the foundation upon which all other HIV/AIDS health and human service programs are built." The plan identified the need for regional care coordination on a statewide basis, site communication, and the standardization of data collection and intake procedures. By the early 1990's two sites were well established as service providers, the AIDS Task Force in Fort Wayne and the Damien Center in Indianapolis. As the plan for provision of statewide services evolved, pilot projects in Evansville and Gary were established and overseen by the Damien Center. The projects were funded through a small grant from Indiana's Family and Social Services Administration (FSSA).

By 1991, the Division was receiving federal Ryan White dollars. The award was used to implement traditional ADAP and Early Intervention Plan (EIP) programs through a sub-contractor. From the beginning, these services were available statewide.

In 1992, Indiana received its first Title III (now Part C) award. This was the first HIV-specific funding that was allocated for a particular metropolitan area (in this case, Marion County). The project provided access to medical services and some case management activities for those living within its geographical area. Additional Title III programs were funded over the years, both for planning projects and for service delivery.

In December 1992, FSSA transferred the administration of the HIV Care Coordination Program to the Division which then became responsible for issues concerning funding, policy setting, and program administration. By 1993, the number of care sites had increased to twelve. Since that time, clinic-based medical case management programs have been developed at Wishard and Methodist Hospitals in Indianapolis, and several sites have expanded to include Spanish-language and substance abuse specialists.

Funds for housing and emergency assistance were first received in 1993 and administered by a sister agency of the ADAP sub-contractor. (These two agencies eventually merged.) Like ADAP and EIP, these services were immediately available around the state through the network of HIV Care Coordination sites.

By the end of the decade, administration of the housing program was transitioned to the Indiana Housing and Community Development Authority, and the Division also ended its relationship with the sub-contractor. As all medical services were brought in-house at ISDH, the program shifted from its focus on ADAP and developed a new

insurance-based service. Leveraging premium payments made to the state's high-risk insurance pool, the Division doubled the number of its enrollees in less than a year and was able to offer comprehensive medical coverage rather than only the traditional ADAP and EIP services.

Currently, Indiana boasts two Part C clinics, a strong partnership with the neighboring Part C clinic in Northwest Kentucky, a free statewide insurance-based HIV Medical Services Program, a statewide HIV housing program, an HIV substance abuse support program, a new Part A project of the Indianapolis transitional grant area, and a regional Midwest AIDS Training and Education Center (MATEC).

Assessment of Service Needs

The Division regularly conducts activities designed to ascertain the service needs of Indiana's HIV-positive population. The information gathered from these activities is used in conjunction with that supplied by OCDR to develop service delivery plans that address the identified needs and barriers to quality care. The following paragraphs briefly describe the most significant activities to date.

1. State Needs Assessment Report 2002

For some time, the primary source of information used to create the Statewide Coordinated Statement of Need has been the state's official HIV/AIDS Needs Assessment Report, which was prepared in February 2002 by the Partnership for Community Health, Inc., a consulting agency based in New York. The complete needs assessment contained three separate reports. The first was an epidemiological report which provided a profile of potential service recipients. The second report described the findings of the actual needs assessment and presented the quantitative and qualitative information obtained through surveys and focus groups with 404 HIV-positive persons from various sub-populations including African Americans, Hispanics, heterosexual men and women, and injection drug users. This assessment report addressed absolute service needs, perceived needs or demands, fulfilled needs, absolute unmet needs, unmet perceived needs, and barriers to care as identified by HIV-positive persons. The third report incorporated information gathered from service providers in order to estimate the capacity of the system and any related gaps.

Four different data collection methods were used by the Partnership for Community Health for this project.

- a. A review of secondary information (including epidemiological and service utilization data provided by ISDH) was performed to estimate the HIV and AIDS incidence and prevalence rates, the sampling frame, the number of service units provided by the care system, and the general health status of HIV-positive persons in Indiana.
- b. A survey was conducted among a representative sample of HIV-positive persons, many of whom were identified as out-of-care or belonging to difficult to reach populations. The survey provided updated demographic estimates, as well as information on co-morbidities, service awareness levels, and adherence rates. It also gathered data related to the perceived knowledge, demand, utilization, and barriers related to particular services.
- c. Sixteen focus groups were conducted among target populations, along with key informant interviews. These sessions provided an in-depth view of the needs and barriers to services and helped to validate findings from the survey.
- d. A provider information form was circulated to collect information on the services provided, funding for services, number of clients served, unduplicated client counts, and providers' perceptions of service barriers.

2. Consumer Satisfaction Survey 2003

The Division conducted a satisfaction survey of its HIV Care Coordination and HIV Medical Services Program clients in the spring of 2003. The responses were submitted to sociologists Carrie E. Foote-Ardah, Ph.D., and Eric R. Wright, Ph.D., at Indiana University – Purdue University at Indianapolis for analysis. The resulting report was reviewed by the Division and circulated to the advisory council.

The survey included a battery of questions developed to measure client satisfaction with each program. Part A of the questionnaire pertained to case management services, Part B to medical services. Satisfaction was measured using a five point Likert scale in response to positive statements about the programs such that agreement corresponded with satisfaction. Additional questions gathered the client's gender, race, current program enrollment status, length of enrollment, and place of service. A total of 726 questionnaires were returned and analyzed.

3. Women and Families Needs Assessment 2003

The "Indiana HIV/AIDS Women, Children and Families Needs Assessment Study" was conducted in 2003 with HIV-positive women and HIV Care Coordination staff from around the state. Dr. Carrie E. Foote-Ardah, working in conjunction with the Family AIDS Network, initiated a statewide exploratory assessment of the needs of

women, children, and families impacted by HIV. The study documented the HIV-related needs of women and children in the State of Indiana with specific attention to the nature and quality of available supportive and care resources (e.g., housing, case management, medical care, legal services, child and family services, transportation, mental health, substance abuse, support groups), the experiences and satisfaction with services used, the barriers to supportive services and care resources, and the changes needed to improve existing services and the lives of women and children impacted by HIV.

The study consisted of three phases. Phase one consisted of administering a small survey to 125 staff members from the HIV Care Coordination sites across Indiana. Staff included program managers, HIV Care Coordinators, prevention specialists and substance abuse counselors. Data were collected from 90 of these staff members regarding the services offered to women and children at their respective agencies (if any), the perceived service needs of women, any perceived barriers to accessing available services, and possible solutions to existing gaps in services.

Phase two consisted of three focus groups conducted with a smaller sample (32) of the HIV Care Coordination staff in three different parts of the state: north, central and south (representing 12 care sites). Although groups were not representative of the entire staff population, they were very diverse with regard to key demographics. Through the focus groups, more in-depth data on women and children service needs and barriers were collected emphasizing HIV Care Coordination experiences.

Phase three consisted of seven focus groups (involving 60 total participants) and in-depth interviews with two additional HIV-infected women. Of the participants in this phase, 51% were Black, 43% were White, and 6% were Hispanic or "Other" races. Nearly all had at least one child (88%), and 76% were currently taking HIV medications. Separate focus groups were completed in different parts of Indiana (two in central and one each in east central, northeast, northwest, southeast, and southwest Indiana). Data gathered paralleled that collected from care site staff but emphasized female consumer experiences.

4. State Needs Assessment Update 2004

In the spring and summer of 2004, the Division endeavored to update its 2002 Needs Assessment Report. The Division distributed 466 client surveys to its 15 HIV Care Coordination sites. The surveys asked clients if certain medical and social services were currently needed, available, and being received on a regular basis. Basic demographics were also collected for each respondent.

The Division received 444 completed surveys in response. Males composed 74% of the respondents, females composed 25%, and 1% identified as transgendered. The racial composition of the respondents was Black (35%), White (55%) Hispanic (7%), and Other (3%). Marion County was the best represented county among respondents (37%), followed by Lake (9%), Allen (9%), St. Joseph (9%) and Vanderburgh (5%). All other counties had a response rate of less than 5%.

The design of the questionnaire allowed for the analysis of the degree to which a particular service was needed but not currently available. This discrepancy between need and availability (i.e., the "unmet need") was considered to be of primary importance.

In terms of overall unmet needs, respondents from smaller counties tended to report more needs that were not currently being met. These counties included Lawrence, Owen, Hamilton, Spencer, and Jay. Respondents from larger counties (such as Marion, Lake, and Allen) tended to report fewer unmet needs.

5. Emergency Financial Assistance Project 2004

In October 2004, the Division launched a short-term emergency financial assistance project throughout Indiana. The Division allocated \$600,000 in unobligated Title II funds to the project and used its network of standard HIV Care Coordination sites and a third party payer to implement it. Requests for assistance were coded as either "Agency-Direct" or "Client-Direct." The former were requests for reimbursement of bulk-quantity purchases of items to be distributed by the agency to needy clients. The latter were requests for reimbursement of payments made by the agency on behalf of a particular client. The care sites submitted a total of 1176 unduplicated requests between October 2004 and March 2005.

The raw number of requests was distributed among the regions in this way: Northern (36%), Central (21%), and Southern (43%). The actual expenditure distribution, however, was slightly different – Northern (33%), Central (11%) and Southern (57%). For the "Client-Direct" requests, 22% were submitted for female clients and 24% for non-white clients. These percentages are slightly less than those of the HIV Care Coordination population which is 24% and 41% for females and non-Whites, respectively.

Analyzing expenditures by geographic region, the largest percentages were spent on men in the Southern region (65%) and on women in the North (58%). The expenditures for Blacks and "Other" races were greatest in the North (58% and 91%) and for Whites and Hispanics in the South (66% and 60%).

6. State Needs Assessment Update 2005

In an effort to confirm the continued relevance of data from earlier assessments, the Division conducted a larger-scale survey of its HIV Care Coordination clients in June 2005. The survey was mailed to 1715 individuals and consisted of 22 questions presented in English and Spanish. Of the 550 responses, 544 were in English. The main portion of the survey asked a series of questions about the period of time during which clients experienced a particular hardship (e.g., the number of days in the last month the client was hungry or unable to get food).

While each of the state's HIV Care Coordination regions was represented, the majority of responses were received from the Indianapolis, Gary, and Fort Wayne areas. Most respondents were male (80%) and White (71%). Nineteen percent of the respondents were Black, and 6% were Hispanic. Most respondents (84%) had been receiving HIV Care Coordination services for more than 12 months, and over half (59%) reported an annual income of less than \$12,000.

7. Consumer Focus Groups 2007

In 2007, the Division enlisted the assistance of the Consumer Advisory Board (CAB) to conduct small-scale focus groups throughout the various service regions of the state. For ten months, the members were given a different monthly topic to discuss with other HIV-positive constituents in their respective areas. Among the topics, the Division included its eight priority services which included the six original core services identified by HRSA. Each focus group utilized a simple survey form to document the participants' opinions; some surveys were also administered individually by the HIV Care Coordination staff. The Division received a total of 586 survey responses.

8. Never In Care Focus Group 2008

The Division conducted a focus group in early 2008 with five HIV-positive persons from the central Indiana area who had been identified as "not being in care within 90 days of diagnosis." Most of the participants (80%-90%) were under age 40, and many (60%-75%) appeared to be newly diagnosed and still struggling with the situation. Major barriers to care identified by the group were lack of money, confidentiality, stigmatization by health care workers or other health facility workers, embarrassment about HIV status, and lack of knowledge about where to get care. Most were unsure of whether HIV-positive people should see a doctor on a regular basis and were concerned about relationships with family and significant others. Factors that could improve the likelihood that HIV-positive people will seek or receive care were identified by the group and included: financial incentives, increased confidentiality at health facilities, and stronger messages stressing that health care will prolong life and improve its quality.

9. Part A Transitional Grant Area (TGA) Needs Assessment 2008

After receiving Part A funding in 2007, the Marion County Health Department (MCHD) began to coordinate a community-based needs assessment for the central Indiana HIV population in collaboration with the Health and Hospital Corporation of Marion County. Initial project planning activities began in late 2007, with most of the data collected in early 2008. This project assessed the needs of the HIV-positive population in Marion County and the surrounding areas; identified the real and perceived health-related issues of HIV-positive individuals groups across age, gender, racial and ethnic categories; uncovered the barriers that keep individuals from entering care, staying in care, and being adherent to treatment regimens; and identified opportunities and initiatives that will address those barriers so that the needs of those infected with HIV can be better met. Targeted populations included: women, expectant mothers, substance users, the recently incarcerated, Hispanic immigrants, HIV-positive people residing in the suburban areas surrounding Indianapolis, men who have sex with men (MSM), and minority men with MSM risk factors.

Focus groups and key informant interviews were conducted with local HIV-positive residents and providers with an understanding of the significant needs, potential solutions, and experiences of those with HIV. Responses from the focus groups and key informant interviews were analyzed, serious barriers to health care and other services have been identified.

Based on the information gathered from these activities, specific recommendations were made by the Part A grantee in three areas. First, existing health care system barriers need to be removed by improving the interaction and communication between providers and patients, increasing awareness of services, and increasing the number of providers. Second, programs and initiatives need to be developed to ensure that individuals with HIV have access to basic services addressing social, educational, and employment needs. Finally, basic and specialized medical care services for the target population need to be expanded.

Priority Service Needs

Based on the information obtained through the activities described above, the Division has recognized the following priority service areas: Primary Medical Care, HIV-related Medications, Oral Health, Case Management, Mental Health Treatment, and Substance Abuse Treatment. These correspond with the core service areas established by the HRSA prior to the 2006 Ryan White reauthorization. The Division also notes the importance of Transportation and Housing services. (However, due to their relatively recent inclusion, many of the new core medical and support services prescribed by HRSA in 2006 are not reflected here.) The paragraphs which follow describe Indiana's specific rationale for each category's inclusion as a priority service need.

1. Primary Medical Care

In the 2002 Needs Assessment Report, more than half (53%) of the HIV-positive respondents indicated that primary medical care was the service most necessary to ensuring good health. Regardless of gender or race, respondents consistently ranked medical care as their top need. Even in the absence of severe symptoms, access to treatment, particularly primary medical care, was widely recognized by respondents as absolutely necessary to maintain and improve the health of HIV-positive individuals.

In the Division's satisfaction survey, clients were asked about their experiences in the HIV Medical Services Program. More than two-thirds of these respondents indicated program satisfaction across all items. Among the areas with the highest ratings were: the program's success with helping clients to access medications (84%) and medical care (81%). Though these high levels of satisfaction highlight the importance of the HIV Medical Services Program, some clients (27%) disagreed with the statement that the program covers all of their medical needs. Therefore, in addition to access, securing comprehensive medical coverage is also considered a need in Indiana.

The Needs Assessment Update conducted in 2005 confirmed that access to basic medical care remains one of the most critical needs of HIV-positive persons. Respondents ranked this area second only to pharmaceuticals. The results of the recent Emergency Financial Assistance Project point to the same conclusion. Nearly one-third of the available \$600,000 was used to reimburse physicians, hospitals, and laboratories for HIV-related services that had been rendered. The recent 2007 focus group reports indicated that HIV-positive individuals still consider regular access to quality health care to be essential.

Based on the comments and responses from the interviewees and focus group participants in the 2008 TGA needs assessment, the grantee recommended that basic and specialized HIV medical care services to the target population be expanded in order to meet demand.

2. HIV-related Medication

In the 2002 Needs Assessment report, 12% of the HIV-positive respondents ranked drug cost reimbursements among their most important needs. Though this figure is lower than expected, the development and utilization of new antiretroviral (ARV) agents has been central to the treatment of HIV disease and has increased the life expectancy of infected persons. The documented positive health outcomes arising from the use of these innovative medications have confirmed the continued need for HIV medication assistance. This need for pharmaceuticals is substantiated by other findings within the Needs Assessment Report. According to the report, 54% of the HIV-positive population in Indiana exhibit symptoms that would indicate the need for antiviral treatment (based on the criteria established in the Department of Health and Human Services treatment guidelines).

The Needs Assessment Update of 2005 confirms the importance of access to pharmaceuticals. The majority (more than 40%) of the survey respondents ranked this area as their primary area of need. As expected, the 2007 consumer focus group reports also confirmed that access to medications remains a paramount concern for HIV-positive individuals. Gap analyses show that, as with primary medical care, the high cost of medications continues to be a barrier to care and that enrollment caps, funding restrictions, and narrow eligibility guidelines often prevent immediate access to life-saving pharmaceuticals.

3. Oral Health

Nearly a quarter (24%) of the respondents in the Needs Assessment of 2002 indicated that dental care was the service most necessary to ensuring good health. The report also revealed that dental care is the greatest unmet service need in Indiana. Of all respondents, 65% indicated some level of need for dental services, but only 52% acknowledged that they had received the necessary care. In general, dental care was ranked as the third most important service for HIV-positive persons.

Not surprisingly, the 2004 and 2005 Update surveys confirmed this ranking as well, with 10% of the respondents to the 2005 survey indicating considerable trouble in obtaining dental care services. The Emergency Financial

Assistance Project results are further evidence that Oral Health (or the ability to pay for it) remains a serious concern; nearly 24% of the available funds were used to reimburse dental providers for services rendered.

Consumers in 2007 indicated that there remains a longstanding belief that oral health care is simply inaccessible and unaffordable. Participants still believed that some providers will not treat an HIV-positive patient. The dental benefits provided by Part A, B, and C programs in Indiana are designed to address these perceptions, but the sizeable gaps caused by enrollment caps, funding shortages, geographic limitations, and eligibility guidelines continue to persist.

Also in 2007, the Division of Oral Health added HIV to its Indiana Oral Health Plan, a document which the Association of State and Territorial Dental Directors has defined as a public health strategic plan to systematically address the burden of oral diseases and to enhance the oral health of the state's residents. The plan is based on appropriate oral health needs assessment and surveillance findings at the state and local levels and uses evidence-based interventions that have been shown effective through research. Such a plan is considered key to establishing a vision for improving the oral health and well-being of the residents of the state and local communities, developing policies, and targeting actions. The plan for 2007 included the narrative below.

"Financial restrictions, lack of insurance, lack of available preventive services, and lack of access to restorative services were the reasons cited for visiting a dentist only every 2-5 years. The HIV Cost and Services Utilization Study (HCSUS) concluded that 58 percent of HIV-positive individuals did not seek oral health care in the previous six months. The HCSUS also found that 20 percent of the individuals reported having unmet dental needs and that unmet dental needs outnumbered other unmet health needs by a ratio of 2 to 1."

4. Case Management

In the Needs Assessment Report of 2002, one-fifth (20%) of respondents indicated that case management was the single service most necessary to ensuring good health. The need for case management services was ranked just slightly lower than dental services.

Based on the Division's satisfaction survey results, clients appear very satisfied with their case managers. Across a number of indicators, clients report strikingly high levels of satisfaction with most dimensions of the program. In terms of overall HIV Care Coordination experience, twelve respondents (less than 7%) reported having had a bad experience. Those expressing dissatisfaction were most likely to express concern with accessibility issues (e.g., case manager availability and response time to client concerns).

Case management was again ranked as one of the top five necessary services in the 2005 Needs Assessment Update survey. Most respondents (84%) indicated satisfaction with the competency of their case managers. The 2007 focus group reports yielded similar feedback regarding the need for and positive satisfaction with Indiana's HIV Care Coordination Program. Respondents believed that case management plays a central role in increasing access to medical and social support services and in decreasing the fragmentation of care.

5. Mental Health Treatment

Mental health treatment did not rank as a priority concern in the 2002 Needs Assessment, neither had it been exhaustively addressed by the Division to date. In the 2005 survey, after respondents chose their top "critical" need, they were asked to indicate which of five additional services was most important to them. Mental Health Treatment received the third largest number of responses (more than 15%). In 2007, the Consumer Focus Group participants provided a wealth of qualitative information regarding the importance of good mental health care. Many believed that their mental health diagnoses had a greater impact on their overall health and well-being than did their HIV-positive status. Mental health was associated by the respondents with daily living skills and self-care in general. Some proposed that HIV-positive persons may view the mental health care community as more judgmental than the medical communities and, therefore, may be less likely to seek this type of care.

6. Substance Abuse Treatment

Like mental health services, substance abuse treatment did not rank as a major concern on the 2002 Needs Assessment. By 2005, little had changed. Of the five secondary services from which to choose on the 2005 survey, respondents chose Substance Abuse Treatment least often (less than 7%). Given the anecdotal evidence available through case management program audits, this percentage is surprisingly low, though it is expected that the issue would be drastically under-reported – even in anonymous settings – due in part to its illicit nature. The qualitative data gathered during the 2007 consumer focus group process indicated that disclosure of a substance use issue remains difficult. Few respondents to the surveys – though demographically and geographically diverse – were willing to report personal chemical dependency concerns; although, overall, the concept of low-cost or free drug treatment was supported by respondents provided that such services were

not promoted as “mental health care,” interestingly pointing to possibly greater stigma attached to mental health than to drug abuse.

7. Transportation

In the Needs Assessment Report of 2002, nearly one quarter (24%) of the respondents indicated that transportation was the service most necessary to ensuring good health. While access to this type of service is regarded as essential to quality of life, consumers consistently report that they are unable to obtain the service on a regular basis. The inability to find affordable, reliable methods of transportation is often cited as a reason for failure to access services that are otherwise available.

A substantial portion of the Emergency Financial Assistance Project funds (nearly 5% or approximately \$30,000) were used to address transportation-related needs in 2005. The Needs Assessment Update of the same year indicated that a significant proportion of the respondents missed work or were unable to obtain their medications (22% each) due to the unavailability of adequate transportation.

8. Housing

Consumers often require housing (and utility) assistance in order to maintain an adequate standard of living. Housing assistance in Indiana is generally confined to short- or long-term rental assistance. Those without access to assistance of this kind are often in jeopardy of hunger and homelessness. In 2003, AIDS Housing of Washington drafted the Indiana HIV/AIDS Housing Plan for the Indiana Housing and Community Development Authority, the City of Indianapolis, and the Damien Center. The plan identified affordability as the primary barrier to accessing housing for HIV-positive people in Indiana. In every region of the state, it is extremely difficult to find safe and sanitary housing that is affordable for low-income individuals.

The preliminary analysis of the Women and Families Needs Assessment data reveals that the presence of children in the household intensifies the need for housing assistance and brings with it the additional need for child care. Nearly all care site staff (89%) reported child care as a significant need for their clients, yet 43% of staff indicated that this service was not available. In general, child care was ranked as the fourth most important auxiliary service need (after case management, mental health care, and housing) for women.

The results from the Needs Assessment Updates of 2004 and 2005 indicated that shelter-related issues continue to impact HIV-positive individuals significantly. In the secondary “additional concerns” tier of the 2005 survey, 30% of the respondents chose housing as the area most important to them. Likewise, the Emergency Financial Assistance Project spent nearly 13% of its funds to reimburse shelter-related providers.

Unmet Need Estimate

In 2003, the Division first calculated the approximate number of persons who are aware of their HIV-positive status but are not actively engaged in care. The original estimate was 4726 persons. The estimate was updated for each of the next five years (to 4246 in 2004, 3657 in 2005, 2911 in 2006, 3362 in 2007, and now 3544 in 2008), each time taking into consideration new information from key sources as well as feedback received from HRSA and Mosaica, a technical assistance contractor.

As in previous years, to develop the 2008 estimate, the Division began by reviewing surveillance data from the OCDR to determine the total size of the population of persons living in Indiana with HIV. As of 31 March 2008, OCDR had 4090 surveillance records for individuals living with HIV and 4865 records for those living with AIDS. These included all confidential case reports originating from Indiana plus all cases reported only through laboratory testing (to account for otherwise unreported in-migration) less all cases known to have expired or relocated out-of-state (to account for out-migration). From these, any record which also had corresponding CD4 or viral load laboratory reports from any in- or out-of-state facility dated between 1 April 2007 and 31 March 2008 was subtracted. There were 2023 such reports for the HIV group and 1621 for the AIDS group.

Medicaid information from the same time period was then solicited from the Office of Medicaid Policy and Planning. Included in this information were claims data for both HIV drug therapy and CD4 and viral load testing. Within this data set, 20 and 38 records matched with names in the remaining HIV and AIDS groups respectively. These names then were eliminated from the prevalence data set.

Finally, utilization data from the Division’s HIV Medical Services Program was reviewed. For the timeframe of 1 April 2007 through 31 March 2008, ADAP and Health Insurance Assistance Plan (HIAP) data were analyzed for evidence of either HIV drug therapy or CD4 or viral load testing. Among all applicable records, 30 matched with the remaining HIV records and 56 matched with the remaining AIDS records. Both groups were eliminated from the balance of prevalence records. The remaining records comprise the state’s unmet need population. For 2008, this population is estimated to consist of 1017 individuals with HIV and 1527 with AIDS.

Table D. 2008 Unmet Need Framework by Stage

Stage 1						
INDIANA PREVALENCE						
Time period	As of March 31, 2008					
Source	Indiana Office of Clinical Data and Research					
Parameters	All confidential HIV case reports originating from Indiana, plus					
	All cases reported only through laboratory testing to account for in-migration, less					
	All cases known to have expired or relocated out-of-state to account for out-migration					
	HIV Diagnosis		AIDS Diagnosis		Combined Total	
	#	%	#	%	#	%
Male	3175	78	4058	83	7233	81
Female	915	22	807	17	1722	19
	4090	100	4865	100	8955	100
Black	1484	36	1609	33	3093	34
White	2276	56	2802	58	5078	57
Hispanic	238	6	355	7	593	7
Other	92	2	99	2	191	2
	4090	100	4865	100	8955	100
< 20	50	1	28	1	78	1
20-29	600	15	227	4	827	9
30-39	1133	28	1062	22	2195	24
40-49	1490	36	2233	46	3723	42
> 49	817	20	1315	27	2132	24
	4090	100	4865	100	8955	100
Heterosexual	737	18	785	16	1522	17
Homosexual	1937	47	2484	51	4421	49
IDU	142	4	277	6	419	5
Perinatal	46	1	33	1	79	1
Other/No Risk	1228	30	1286	26	2514	28
	4090	100	4865	100	8955	100
Subtotal A	4090	46%	4865	54%	8955	100%
Stage 5						
INDIANA "UNMET NEED" POPULATION						
Time period	As of March 31, 2008					
Source	Indiana Office of Clinical Data and Research					
Parameters	Original prevalence population, less					
	All individuals with indications of "met need" according to the established definition.					
	HIV Diagnosis		AIDS Diagnosis		Combined Total	
	#	%	#	%	#	%
Male	1610	80	1307	86	2917	82
Female	407	20	220	14	627	18
	2017	100	1527	100	3544	100
Black	841	42	514	34	1355	38
White	998	49	865	56	1863	53
Hispanic	139	7	135	9	274	8
Other	39	2	13	1	52	1
	2017	100	1527	100	3544	100
< 20	20	1	6	1	26	1
20-29	279	14	50	3	329	9
30-39	581	29	333	22	914	26
40-49	762	38	722	47	1484	42
> 49	375	18	416	27	791	22
	2017	100	1527	100	3544	100
Heterosexual	322	16	203	13	525	15
Homosexual	868	43	787	51	1655	46
IDU	89	4	122	8	211	6
Perinatal	17	1	8	1	25	1
Other/No Risk	721	36	407	27	1128	32
	2017	100	1527	100	3544	100
Subtotal D	2017	57%	1527	43%	3544	100%

Table D shows the first and fifth stages of Indiana's official estimate of unmet need for 2008. It describes the demographics of the original prevalence population as well as those of the final "unmet need" population. Gender, race, age range at diagnosis, and primary risk type are included. Reliable information was not available to include details regarding income or health care coverage for these populations.

This estimate is assumed to be the state's population of HIV-positive people with knowledge of their status but without access to or need for medical care. The Division acknowledges that this estimate has certain limitations. It disregards individuals who may have private insurance coverage but whose recent medical care falls outside of the parameters of the framework. Likewise, it does not take into account the possibility of coverage under the Veterans Administration (VA). Numerous attempts to collect client-level data from the VA were unsuccessful. In 2007, the Division was informed that the regional office did not collect information of this detail at all and referred us to the local VA hospital. The hospital, however, was unable to supply the data despite assurances of confidentiality. Fortunately, the OCDR has provided reassurance that, due to an agreement between the VA and DHHS on the national level, all VA lab information is provided to the state for surveillance purposes and, therefore, information directly from the VA likely would be redundant. Finally, the estimate does not consider a number of other individuals who do have access to care (e.g., the larger HIV Medical Services Program population) if CD4 counts, viral load counts, or specific drugs have not been obtained within the reporting period. Further, by design, it does not define those who are receiving only non-HIV medical services or drugs as "in care."

The current estimate shows that the number of individuals believed to be without primary medical care in Indiana has grown from 3,362 (in 2007) to 3,544 (in 2008). While this 5.4% increase is not alarming, there has also been a major shift between the HIV and AIDS groups; the HIV populations appears to have increased by 45% (from 1,387 to 2,017) while the AIDS population has decreased by 22% (1,975 to 1,527). Table D fully describes the demographic qualities of these groups.

Initial analysis shows that the demographics of the unmet need group resemble those of the entire prevalence group. When the HIV and AIDS subtotals are combined, both groups contain between 81-82% males and 43-47% non-Whites. Approximately 66% and 68% of the prevalence and unmet needs groups, respectively, are 30-49 years of age, and approximately 49% and 46% indicated same-sex risk factors. The unmet need group also seems to be located around the state in similar patterns to the larger prevalence group. Based on the available information, roughly one-quarter reside in Northern Indiana, one-half in Central Indiana, and one-quarter in Southern Indiana. This appears to indicate that particular subpopulations are not impacted disproportionately by access-to-care issues; therefore the results of this exercise did not significantly impact the design of the service delivery model or the resources allocated to provide services.

However, comparing this data to the previous year's estimate, some remarkable changes can be seen in various demographic qualities. In the HIV group, Blacks increased from 32% to 42% while Whites saw a concomitant reduction from 60% to 49%. Additionally, there was a slight shift among the age groups; the percentage of those in the HIV group in the 40-49 age group rose slightly from 33% to 38%. For all cases which identified a possible mode of transmission, heterosexual contact decreased from 18% to 15% while injection drug use risk increased from 4% to 6%. The number of individuals unwilling to disclose a risk behavior rose from 26% to 32% between 2007 and 2008; this phenomenon was discussed earlier in the Epidemiological Profile section. Overall, the increase in the number of persons in the 2008 estimate may be attributed to an increase in those diagnosed with AIDS at their first test for HIV in the prevalence population (before care can be initiated).

Based on the constant and substantial size of the estimated "unmet need" population, the Division recognizes that one of the primary gaps in care continues to be an inability to consistently engage and maintain HIV-positive persons in services and treatment. To address this issue, the Division continues to conduct a number of activities to identify HIV-positive individuals who are not actively seeking care. Many of these activities are not associated with Part B funding.

Currently, the state-funded HIV Care Coordination Program oversees 14 agencies that work closely with service providers across the state to coordinate medical care, health insurance for the uninsured, and social services. Many out-of-care consumers are brought back into care through referrals into this network. In Marion County specifically, the Part A-funded Channels of Hope project (formerly the Emerging Communities HIV Support Center) has been highly effective in its efforts to capture consumers who have been "lost to care," bringing them back into the system to receive necessary social and medical services.

Procedure within the Division dictates that, for persons who test HIV-positive but do not return for their test results, a Disease Intervention Specialist will be dispatched by the OCDR to deliver the test results in person and to provide information about available services. New specialists receive training regarding the availability of HIV Care Coordination services throughout the state and are trained to provide this information to HIV-positive persons that they encounter. The relationship between the Division's service programs, the HIV Care Coordination agencies, the various counseling and testing sites, and the Disease Intervention system are under continuous review to ensure that the programs are operating synergistically with the common goal of engaging and maintaining persons with HIV in care.

To strengthen its ability to retain consumers in care, the Division established a requirement for all HIV Medical Services Program recipients to engage and remain in the state's HIV Care Coordination Program. This is very similar to the requirements of other HIV services in the state, including Indiana's Housing Opportunities for Persons With AIDS (HOPWA) program. All new applications must originate from – and all recertification interviews must be performed by – the sanctioned care sites where quality control measures can be implemented, if necessary. This requirement has been in effect since 1 January 2004.

Service Gaps and Barriers

In addition to the issues surrounding the task of engaging and maintaining people in care, the Division recognizes a number of other serious gaps and barriers. These exist despite a healthy continuum of care and a wealth of quality service providers. They can be roughly correlated to each of the state's priority service needs and impact both those considered to be in and out of care according to the HRSA definition of “unmet need.” The following paragraphs briefly describe the most evident issues for each priority service need. These gaps and barriers include both the obstacles experienced by the consumer and those facing the providers.

1. Primary Medical Care

- a. The ability to afford primary medical care continues to affect the rate at which HIV-positive persons access such care. Many consumers lack insurance coverage or are unable to pay for services.
- b. “Access-on-demand” is not a reality in Indiana. Despite the Division's funding commitment, the HIV Medical Services Program is unable to serve all of its eligible applicants. The enrollment threshold for the number of enrollees has been reached. A waiting list is in place at this time, and the maximum capacity could be reduced if further premium increases are realized.
- c. Other programs – such as the state's Part A and C programs and Wishard Hospital's Advantage Program – exist with similar funding restrictions, are geographically limited, and are unable to serve every applicant. Strict eligibility criteria also affect how easily a person can access this type of care.
- d. The number of infectious disease specialists is low. General practitioners may be reluctant to treat HIV-positive patients in large numbers due to the complexity of the disease. Low volume providers (such as in rural areas) often have less experience and less training, and this may impact the health outcomes experienced by their patients over time.
- e. The degree to which clients are able to comprehend and successfully use the Division's HIV Medical Services Program is a concern, particularly for consumers of diverse racial or ethnic backgrounds.
- f. The consumer's physical health can prevent timely access to appropriate medical care or may interfere with adherence to prescribed regimens.
- g. Organizational barriers such as “navigating the system,” “dealing with red tape,” and “coordinating services” are often cited by consumers.
- h. Indiana Comprehensive Health Insurance Association (ICHIA) requires applicants to provide proof of a denial from a private insurance provider. ICHIA also requires that each applicant file a Medicaid application; this is a significant barrier to people who are not U.S. citizens.
- i. Consumers report a lack of effective communication with medical providers which may negatively impact the continuum of care.
- j. As consumers become healthier due to available treatments, retention of benefits (such as Medicaid and SSDI) becomes more difficult.
- k. Consumers report that mistrust of the medical establishment (especially among minority populations) often results in a delay of entry into care.
- l. Incarcerated consumers often experience difficulty in accessing health care and other assistance upon release.
- m. The Indiana Medicaid system (including traditional Medicaid, risk-based managed care, CareSelect, and MDWise) remains difficult to understand and navigate. Patients are often auto-enrolled into managed care plans that require them to change providers. The process to correct this issue is lengthy, and patients are often to attend medical appointments until the matter is resolved. In many areas, local offices and case managers have been replaced by “call centers,” the employees at which are often untrained and unfamiliar with the complexities of the HIV service delivery system in Indiana.

2. HIV-related Medication

- a. As with primary medical care, the high cost of medications continues to prevent many individuals from accessing necessary pharmaceuticals.
- b. Limited funding for the Part B-supported HIV Medical Services Program is the most immediate barrier to pharmaceutical access for uninsured HIV-positive individuals. Despite the Division's funding commitment and support from the state's Part A grantee, the HIV Medical Services Program is unable to serve all of its eligible applicants. The enrollment threshold for the number of enrollees has been reached. A waiting list is in place at this time, and the maximum capacity could be reduced in the future if further premium increases are realized.

- c. Narrow eligibility guidelines for Part B services can prevent immediate access to pharmaceuticals.
- d. Hospital-based assistance programs for low-income patients are not available statewide.
- e. Medicaid offers pharmaceutical coverage comparable to that of the HIV Medical Services Program; however, the enrollment process is lengthy and the eligibility standards (which often require applicants be determined disabled by the State Medical Review Team) exclude a large number of potential enrollees. New Medicaid managed care programs have drug formulary restrictions that were not experienced under traditional Medicaid.
- f. The Medicaid guidelines do not allow the recipients to earn an adequate income without jeopardizing their coverage.
- g. The manufacturer-sponsored indigent drug assistance programs are short-term, and the application process is cumbersome for consumers (especially those without case management assistance).
- h. Adverse side effects and potential drug interactions may prevent consumers from accessing available HIV pharmaceuticals and adhering to treatment.
- i. Medicare Part D is an expensive and challenging option for consumers. Those under the age of 65 and enrolled in Medicare Part D are not eligible for the HIV Medical Services Program. Many are also ineligible for “extra help” and are responsible to pay for the premium, deductible, and co-payments for their medications. Depending on the plan chosen, the consumer may experience a period of no coverage (the so-called “donut hole”). Consumers whose pharmacies do not cover Part D plans must change either their pharmacy or their Part D plan, potentially delaying their ability to obtain medications.

3. Oral Health

- a. Dental care is only covered by the HIV Medical Services Program during the first three months while the enrollee is in the pre-existing condition period for insurance. ICHIA has no dental benefit.
- b. The out-of-pocket costs for dental care can be prohibitive to many HIV-positive consumers.
- c. The Part A and C dental services are limited to certain clinic-based providers and are only available in three areas of the state.
- d. Many private dental providers do not accept Medicaid or have waiting lists for Medicaid patients.
- e. Many private dentists are not prepared to manage the special oral health needs of those with HIV disease. Some dental providers in rural areas are unwilling to treat patients with HIV.
- f. Many important dental services (such as extractions and dentures) are often limited on coverage formularies.
- g. Consumers report that dental hygiene is not often considered a priority due to other more urgent needs (such as shelter and food).
- h. Consumers remain unaware of available low-cost dental service options.
- i. Other resources have serious limitations; the emergency dental clinic at Wishard Hospital serves people only on a walk-in and on first-come-first-served basis. The various assistance projects maintained by the local HIV Care Coordination sites throughout the state are limited by the level of local community support.

4. Case Management

- a. The Division’s HIV Care Coordination is available to all HIV-positive residents at no cost through 14 care sites around the state. The program continues to expand each year despite decreasing funding. State block grant funding for the HIV Care Coordination Program has been decreased 18% between 2001 and 2008. While no one has been declined HIV Care Coordination services to date, continued funding reductions will ultimately impede the Division’s ability to provide this service without restrictions.
- b. Staffing statewide is not adequate to meet demand. More than half of the HIV Care Coordination sites within the ISDH network are managing caseloads that exceed the maximum acceptable case manager-to-client ratio of 1:40.
- c. “Life issues” are proving to be harder to manage than “death issues.” As clients live longer, their needs have evolved to include issues that previously would not have been within the scope of HIV case management. These issues include employment, family planning, and budget counseling. Clients with multiple health issues are particularly difficult to manage.
- d. HIV Care Coordinators are not uniformly knowledgeable about issues and services that are unique to women, children, and families.
- e. Due to lack of state services, many case managers are beginning to develop a sense of hopelessness about their ability to improve the lives of their clients.
- f. HIV Care Coordination sites are not uniformly equipped to manage non-English speaking consumers.
- g. HIV Care Coordination grantees are not adequately funded to allow for sufficient outreach efforts to take place in under-served populations.
- h. HIV Care Coordination grantees are not adequately funded to allow for the development of targeted support programs (e.g., peer support, group support, educational workshops) for specialized populations (e.g., detainees, sex workers, women, children, minority groups).

- i. Complementary support programs (such as the HIV Support Center and the Special Populations Support Program) are not available in every area of the state.
- j. Consumers report a perception of disparate treatment among case management clients.
- k. Consumers report a perception of inconsistent quality between the various case management providers.
- l. HIV Care Coordination services are not routinely available during evening hours or on week-ends to address emergency situations.
- m. HIV Care Coordination providers are not uniformly equipped to provide the highest level of medical case management and adherence support, and some may not be well connected with the physician community.

5. Mental Health Treatment

- a. Access to affordable mental health treatment is fairly limited in Indiana for those with low incomes or without insurance. The out-of-pocket costs for mental health care can be prohibitive to many HIV-positive consumers.
- b. During the pre-existing condition period, the HIV Medical Services Program covers only the cost of a small number of anti-depressant and anti-anxiety drugs. Once this period has expired and full insurance benefits are available, the enrollee is covered for only 20 out-patient visits for mental health and substance use issues combined. In-patient visits are limited to a combined 180 days for major medical, mental health, and substance abuse treatment. ICHIA utilizes an industry-standard drug formulary that includes most psychotropic medications.
- c. The Part A and C mental health services are limited to out-patient treatment, specific providers, and are only available in three areas of the state (Part A in the Indianapolis TGA and two Part C programs in the Northern and Southern parts of the state).
- d. Many private mental health providers do not accept Medicaid or have waiting lists for Medicaid patients.
- e. Many traditional mental health providers are not equipped to address the disclosure, sexual, and chronic illness issues that may accompany an HIV-positive diagnosis.
- f. Many consumers are reluctant to seek mental health treatment due to the stigma of such a diagnosis.

6. Substance Abuse Treatment

- a. The out-of-pocket costs for addictions treatment can be prohibitive to many HIV-positive consumers.
- b. The Part B HIV Medical Services Program provides very limited access to withdrawal management medications and addictions treatment services until insurance begins. ICHIA allows for coverage of only 20 out-patient visits for mental health and substance use issues combined. In-patient visits are limited to a combined 180 days for major medical, mental health, and substance abuse treatment. ICHIA utilizes an industry-standard drug formulary that does not include specific withdrawal management medications such as Methdone.
- c. The Part A and C substance abuse services are limited to out-patient, specific providers, and are only available in three areas of the state (Part A in the Indianapolis TGA and two Part C programs in the Northern and Southern parts of the state).
- d. Assistance with preparatory counseling is available only in certain areas of the state. The Division funds eight agencies across the state to provide intensive supportive care services designed to prepare the consumer for entry into treatment. Often, as affordable treatment options fail to appear, the support specialist will act as the pro tem treatment professional, working to encourage harm-reduction strategies, HIV medication adherence, and engagement with other care systems.
- e. Many in-patient substance abuse treatment facilities have waiting lists for Medicaid and other patients and are unable to absorb new patients at the most advantageous time.
- f. Many consumers are reluctant to seek substance abuse treatment due to the stigma of having such a condition.
- g. Many substance abuse treatment providers do not emphasize harm reduction and, therefore, limit the number of consumers willing to seek treatment following a relapse.

7. Transportation

- a. None of the Ryan White programs in Indiana operate a large-scale transportation program currently. Transportation paid by Medicaid is contingent on coverage and limited to only approved "medically necessary" travel.
- b. Affordable public transportation in rural (and some suburban) areas is scarce. Where available, public transportation can be difficult to use for consumers with children.
- c. Personal transportation is often unaffordable for HIV-positive persons who are unemployed or living on a limited income.

8. Housing

- a. The majority of housing services for HIV-positive individuals in Indiana are provided by the Indiana Housing and Community Development Authority through the HOPWA program. (In Indianapolis, HOPWA is

coordinated by the City of Indianapolis.) Sub-grants are awarded to the local HIV Care Coordination agencies to distribute to its clients determined to be most in need. Strict eligibility criteria apply, and the client remains responsible for a portion of the housing cost. Currently, nearly every region is maintaining a waiting list for this form of assistance and cannot satisfy the demand for assistance.

- b. HOPWA now imposes a limit on the duration and type of assistance.
- c. Waiting lists also exist for many public housing programs, including Section 8.
- d. Many available options impose restrictions which prevent certain populations (e.g., the incarcerated) from being eligible for service.
- e. Affordable housing is limited and is often unacceptable for the disabled population. Housing options (including shelters) are especially limited for women with children.
- f. Housing-specific case management is not uniformly available in all areas of the state.

Special Consideration for Underserved Populations

The Division strives to serve the various demographic groups in proportion to their representation in the prevalence statistics. Since 2005, the Division has been successful in meeting its goals for women, infants, children, and youth (commonly referred to as the WICY). Other goals, however, have been elusive. The Division has yet to reach its goal percentage (35%) for Black enrollees in the HIV Medical Services Program, despite prioritization of these applications. This may be partially due to the disproportionate enrollment of HIV-positive Black persons in Indiana Medicaid (39%), making them ineligible for Part B services.

The Division has been more successful in proportionately serving Hispanics, partly due to the reality that the undocumented sub-population is often ineligible for many other State and Federal programs. However, the language barrier and a simple lack of knowledge about the service delivery system continue to be challenges. Fear of deportation can keep some from seeking services even if they are aware of and are otherwise eligible for them. In the most desperate cases, individuals may falsify information in order to obtain employment, housing, or benefits, putting themselves at risk for deportation and other legal ramifications.

Prevention Needs

ISDH administers 18 grant-funded projects through its HIV Prevention Program. These projects provide an assortment of prevention interventions, including traditional Counseling, Testing and Referral Services, Partner Counseling and Referral Services, Group Level Interventions, Outreach, Disease Intervention Services, and Comprehensive Risk Counseling Services. The program serves 58 of the 92 counties in Indiana.

The HIV Prevention Program collaborates regularly with other programs within the Division to improve service provision. The HIV Prevention Program works especially closely with the Hepatitis Program to provide services to extremely high-risk individuals diagnosed with Acute Hepatitis B or C. The program's Prevention Counseling service is a standard referral used frequently by the HIV Care Coordinators for clients who have been assessed as having an exceptional potential for continued high-risk sexual behavior.

In 2005, the HIV Prevention Program successfully provided "HIV 101" and testing training in Spanish in an effort to address the rapid growth of the Hispanic population in Indiana. From this collaboration, a number of service needs were identified, most of which related to inadequate funding. In 2006, Counseling, Testing and Referral Services training was provided in Spanish and 7 new individuals were certified to provide Counseling, Testing and Referral Services in Spanish. To further expand the Prevention Program requires additional funds to provide services in Spanish uniformly throughout the state. There is also a lack of sufficient funds to support Prevention Counseling services or new projects (such as *Prevention with Positives* and *Prevention into Care*) in an effective manner.

Section 1, Part 2 – CURRENT SYSTEM OF CARE

Brief Description of the Part B Program

With regard to the Part B funds, the provision of comprehensive medical services is considered to be the Division's first priority. This funding, therefore, is largely dedicated to the operation of the Division's primary HIV health care project: the HIV Medical Services Program. This program consists of the ADAP, EIP, HIAP which works in conjunction with the state's high-risk insurance pool (ICHIA), and the Medicare Part D Assistance Plan (MDAP). Together, these plans ensure that eligible applicants have access to quality health care coverage at little or no cost. The program serves HIV-positive Indiana residents who are uninsured, ineligible for Indiana Medicaid, living at or below 300% of the Federal Poverty Level, and participating in HIV Care Coordination. The program is currently operating at its capacity of 1290 enrollees and a waiting list is in place.

Continuum of Care

The Division maintains that a robust service continuum begins with a commitment to providing free, comprehensive case management services for people testing positive for HIV. The HIV Care Coordination Program, supported largely through state appropriations, is considered to be the "backbone" of the service delivery system and serves as the gateway to every other major HIV-related service in the state. The Division is similarly committed to providing low- or no-cost medical services and pharmaceuticals to the maximum number of eligible individuals who can be supported with existing funding. This goal is achieved through the efficient operation of the HIV Medical Services Program. These programs, along with others that address the state's priority service needs, are described in the sections below.

1. Primary Medical Care

The Division provides access to medical care primarily through its HIV Medical Services Program. This program has two main medical care components: EIP and HIAP. EIP provides immediate access to a limited array of HIV-related health care procedures. EIP benefits expire after approximately three months, at which time the HIAP benefits become effective for the coverage of overall health care. More comprehensive than EIP, HIAP ensures access to full coverage medical care. The program leverages its funding by purchasing insurance for enrollees through the state's high-risk insurance pool, ICHIA. HIAP pays for the premium and other expenses associated with the ICHIA policies. These plans are available to Indiana residents who are HIV-positive, earn less than 300% of the federal poverty level, are otherwise uninsured, and under the age of 65. The Division allotted more than \$11.6 million to maintain its medical services in FY2008-2009.

Additional access to primary medical care is provided through the Part A program in Indianapolis which provides clinical services to eligible residents of the Indianapolis TGA. The majority of the primary medical services are provided by Wishard Hospital, Clarion Health Services (LifeCare), the African Center, and Raphael Health Services. Some insurance assistance is also provided through a partnership with the Division to provide access to insurance. The clinical services are designed to supplement existing health care services in the Indianapolis area. These clinics provide access to quality early interventions, out-patient medical care, and necessary laboratory services as a stop-gap measure until the consumer can be transitioned into more comprehensive programs. The Part A program defines outpatient ambulatory medical care as the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Services typically include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection is expected to be consistent with the Public Health Service guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies.

MCHD supports two complimentary projects through its Part C Program. Primary health care services are offered through Wishard Hospital and the LifeCare Program of Clarian Health. These sites provide services to residents of Marion and the surrounding counties at little or no cost. The Part C project in northwest Indiana, located within the East Chicago Community Health Center, provides the same types of services to residents of Lake County and its neighboring regions. A third Part C clinic based in Kentucky (Matthew 25 AIDS Services) provides client care in southwest Indiana.

Indiana Medicaid also serves a large number of HIV-positive individuals, providing a comprehensive array of health services to those who meet the strict eligibility requirements. In the year ending 31 March 2008, Indiana

In this section...

- Brief Description of the Part B Program
- Continuum of Care
- Resource Inventory
- Profile of Ryan White Providers

Medicaid served nearly 2100 individuals with a primary diagnosis of HIV. A combined total of nearly \$17 million was spent to provide in-patient and out-patient services to these enrollees.

In late 2007, Indiana launched the new Healthy Indiana Plan (HIP), a state-operated health insurance plan for adults. It provides a comprehensive package of benefits through private insurance providers. Its enrollees pay a determined amount each month into an account to cover a portion of their allowable expenses. Enrollees who do not make monthly payments will be terminated and cannot reapply for 12 months. The plan's eligibility criteria limit its membership to persons with family incomes less than 200% of the federal poverty level who have been uninsured for 6 months or more and are not eligible for employer sponsored health insurance. Participants must contribute up to 4.5% of their gross family income into a health savings account, and complete insurance protection starts once annual medical costs exceed \$1,100. The impact of this new plan on the HIV service delivery system is still being evaluated.

2. HIV-related Medication

The Division provides access to HIV pharmaceuticals through its HIV Medical Services Program. The program has three pharmaceutical components: ADAP, HIAP, and MDAP. ADAP provides immediate access to a limited formulary of HIV-related drugs. The formulary is updated regularly and includes all of the drugs that have been FDA-approved for the treatment of HIV disease. Like EIP, ADAP benefits expire after approximately three months, at which time HIAP becomes effective. More comprehensive than ADAP, HIAP provides access to most FDA-approved pharmaceuticals through its full coverage insurance benefits. ADAP is available to Indiana residents who are HIV-positive, who earn less than 300% of the federal poverty level, and who are otherwise uninsured. HIAP is available to these same residents but only until the age of 65. Once an enrollee ages to 65, MDAP is provided to ensure an equivalent level of benefit. MDAP coordinates coverage with a variety of participating providers under the Medicare Part D prescription drug plan. It pays for the deductibles, co-insurance, and co-payments for charges allowed by the approved Part D plan. MDAP coverage is dependent on Part D enrollment and is not available to those under 65 years of age. MDAP also does not pay for the Part D plan premiums; these are the responsibility of the enrollee. The Division allotted more than \$11.6 million to maintain its medical services in FY2008-2009. The Division also reclaims approximately \$200,000 annually in drug rebates from the pharmaceutical industry; these funds are always directly re-applied to the ADAP budget.

In the TGA, the Part A program provides access to HIV pharmaceuticals through its local AIDS Pharmaceutical Assistance Program. This limited program provides emergency coverage for drugs and is not considered a full-scale pharmacy or ADAP program. The program is currently working with Wishard Hospital Pharmacy and BioScrip to provide free medications to eligible consumers who have no other current source of drug coverage.

The state's Part C programs do not cover pharmaceutical costs, though the project in Northwest Indiana does work closely with an HIV specialty pharmacy in their area.

Indiana Medicaid regularly serves nearly 2100 individuals with a primary diagnosis of HIV annually. In the year ending 31 March 2008, nearly \$11.1 million was spent to provide identifiable pharmaceutical services to eligible Medicaid enrollees with an HIV diagnosis code. This is known to include nearly \$6.7 million in identifiable ARV therapy costs in the period.

Nearly all of the HIV drug manufacturers sponsor emergency or "indigent" assistance programs for patients without the ability to pay for certain medications. These programs offer a limited supply of medication and are designed to allow the patient time to arrange for other pharmaceutical coverage. HIV Care Coordinators are trained to assist clients with applying for these programs.

Some hospitals in Indiana offer special assistance programs for low-income patients. Wishard Hospital in Indianapolis, for example, operates the Wishard Advantage program which provides in-patient, out-patient, and pharmaceutical services on a sliding scale payment basis to residents of Marion County. Wishard care coordinators and pharmacists work with clients to obtain medications quickly in hopes of ensuring adherence. Wishard applies for and has been granted funds from the Indiana AIDS Fund for the past several years for a Direct Emergency Financial Assistance (DEFA) project; Wishard uses the DEFA funds to provide medication vouchers to cover the cost of co-payments at the Wishard Pharmacies when patients are unable to pay. Wishard care coordinators and other staff also assist uninsured patients with Patient Assistance Program applications on a regular basis. The Wishard Pharmacy can provide an emergency 10-day supply of medication to a patient once every six months if a gap in insurance coverage occurs.

Other standard HIV Care Coordination sites in the state also receive DEFA funds or have developed their own internal projects using resources from fund-raisers. These projects can also provide emergency access to medications and help with co-payments. These stop-gap projects are crucial in helping clients maintain

adherence to their medication regimens and their Plans of Care. Within the care plans, case managers include other potential community resources to help guarantee access and adherence to medications in the absence of longer-term solutions such as Medicaid or the HIV Medical Services Program.

Finally, Indiana launched the aforementioned HIP initiative in 2007. This state-operated health insurance plan for adults provides a comprehensive package of benefits, including prescription medications, through private insurance providers. The impact of this new plan on the HIV service delivery system is still being evaluated.

3. Oral Health

The Division maintains a limited number of dental services on its EIP formulary. These include initial prophylaxis, periodic exams, and panoramic x-rays. These oral health care benefits expire when the HIAP plan begins; dental care is not covered by the high-risk insurance pool. To address this limitation, the Division of HIV/STD, working in conjunction with the Division of Oral Health, regularly disseminates a statewide directory of dental clinics for low-income individuals to its HIV Care Coordination network.

In the TGA, the Part A program provides access to numerous oral health services through contractual arrangements with the Indiana University School of Dentistry, Raphael Center, and the Marion County Department of Health. Services includes diagnostic, preventive, and therapeutic procedures provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

In central Indiana, MCHD uses a portion of its Part C funding to offer dental services through Citizen's Health Center, Indiana University School of Dentistry, Regenstrief, Grassy Creek and Cottage Corner, and the MCHD Pecar Dental Clinic in Indianapolis. There are currently no service caps. Consumers are responsible for a small co-payment per service based on a sliding pay scale. The Part C project in northwest Indiana offers dental services through an arrangement with Premier Dental, a major dental provider for HIV-positive persons in the area. Under this program, eligible patients are allowed up to \$1200 worth of free dental services per year. The Part C project in southwest Indiana, Matthew 25 AIDS Services, uses a portion of its funds to pay for routine dental services. Dental treatment plans are reviewed by the program administrator and approved for payment pending the availability of funds.

Other resources include an emergency dental clinic at Wishard Hospital and various assistance projects maintains by the local HIV Care Coordination sites throughout the state (funded largely by community support).

Indiana Medicaid covers the largest array of dental procedures. However, the program imposes a \$600 annual cap on dental services per member. Once this threshold is reached, the member must optimize other resources such as the low-income dental clinics.

4. Case Management

The Division, using funding from the state and from a block grant, currently operates a statewide network of more than 55 case managers stationed at fourteen HIV Care Coordination sites. MCHD supplements this program by providing Part C funding for an additional non-medical case manager at one of the central Indiana care sites and one medical case manager at a primary medical site. Each site provides comprehensive case management services to consumers seeking assistance. The HIV Care Coordination Program serves approximately 3300 individuals per quarter.

The program consists of goal-oriented activities that serve to locate, facilitate access to, and monitor the full range of HIV-related services in cooperation with the client. It encourages the most cost-effective use of medical and community resources and promotes the overall well-being of the individual. It respects cultural diversity, emphasizes confidentiality, and strives to ensure the client's freedom of choice and self-determination. Its comprehensive and compassionate services are rendered in a safe, secure, and non-judgmental environment and are provided without cost to the client. The Division currently expends approximately \$2.5 million annually to maintain its 14 care sites, its series of continuing education trainings, and its related quality management activities.

In the TGA, the Part A program provides medical case management through contractual arrangements with three entities that also provide primary HIV medical care. These entities provide a range of client-centered services designed to ensure timely and coordinated access to medically appropriate levels of care, to provide regular reassessment of the needs and support systems of the clients and their families, and to support overall continuity of care. Medical case management includes the provision of counseling to ensure readiness for – and adherence to – complex HIV treatments. Key activities include the initial assessment of service needs; the development of a comprehensive, individualized service plan; the coordination of services required to implement the plan; client monitoring to assess the efficacy of the plan; and a periodic re-evaluation and adaptation of the

plan as necessary over the life of the client. It also includes client-specific advocacy and the review of service utilization. The Part A program also funds non-medical case management at three additional agencies: Damien Center, Concord Center, and the Bethlehem House.

5. Mental Health Treatment

The Division's role in addressing mental health care is limited to the services available through HIAP and the associated insurance policy. HIAP enrollees are covered for only 20 out-patient visits for mental health and substance use issues combined. In-patient visits are limited to a combined total of 180 days for major medical, mental health, and substance abuse treatment. Basic psychotropic medications are covered.

In the TGA, the Part A program funds four service providers to provide mental health services to eligible enrollees. Funded mental health services include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the state to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

The mental health care benefits of the state's Part C programs are also limited. Services are generally provided through local contracted mental health care facilities and usually include bio-psychosocial assessment, psychiatric evaluation, psychological evaluation, individualized counseling, and group and (in some areas) family support. The MCHD's Part C program does not reimburse for mental health services because MCHD's Part A program funds these services.

6. Substance Abuse Treatment

Annually, Indiana's Department of Mental Health and Addiction (DMHA) receives an award according to Title 45, Part 96, Subpart L of the Code of Federal Regulations. DMHA subcontracts a small portion of Indiana's annual award (currently approximately \$900,000) to the Division to implement Special Populations Support Program (SPSP) services. The Division, in turn, grants awards to specific entities in different communities throughout the state to perform the necessary testing and supportive care activities.

SPSP also employs certified HIV testing counselors who have been specially trained to perform comprehensive risk assessments, pre-test counseling, testing, and post-test counseling with the substance using population. The testing counselors conduct their testing activities in a variety of venues where the target population can be found, including the statewide treatment facilities sanctioned by DMHA.

HIV-positive individuals are referred to the program's support specialists who engage the consumer with interventions designed to minimize substance use and maximize compliance with all applicable treatment plans. The specialists work closely with the local HIV Care Coordination agency to ensure that the consumer receives a full complement of care.

Overall, SPSP strives to minimize the negative impact of substance use on the health of persons at risk for or living with HIV disease. The Division currently funds a total of eleven agencies across the state to provide these free SPSP services. Two agencies provide supportive care, three provide counseling and testing services, and six provide both of the components of care offered through this unique program.

A complement to SPSP supportive care services, the Access To Recovery (ATR) program provides financial reimbursement for various treatment and support services to participating providers based on a pre-determined fee schedule. ATR is funded directly by the Substance Abuse and Mental Health Services Administration and is administered jointly by Indiana's Family and Social Services Administration and the Office of Faith-Based and Community Initiatives. Currently, the program serves seven counties, including Lake, St. Joseph, Elkhart, Allen, Marion, Vigo, and Vanderburgh. Its three target populations include those recently released from incarceration, drug-addicted women who are pregnant or have dependent children, and methamphetamine addicts. ATR will provide financial reimbursement for various services to participating providers based on a pre-determined fee schedule.

Reimbursable ATR clinical services include: clinical assessments, intensive outpatient, integrated treatment for co-occurring disorders, and detoxification. Recovery support services include: transportation, relapse prevention, addiction education, housing assistance, peer services, family and marital counseling, employment services, faith and community support, parenting services, supportive education, and alcohol and other drug screening. ATR allows for consumers to choose providers for services who have agreed to participate in the program and are well-versed in serving this challenging population.

The Division also addresses substance abuse treatment through HIAP and the associated insurance policy. HIAP enrollees are covered for only 20 out-patient visits for mental health and substance use issues combined. In-patient visits are limited to a combined total of 180 days for major medical, mental health, and substance abuse treatment.

The Part A program has increased access to substance abuse treatment for eligible enrollees in the Indianapolis TGA. Its out-patient substance abuse program provides medical and counseling services to address addiction issues in an outpatient setting, rendered by a physician, by a professional under the supervision of a physician, or by other qualified personnel.

The addictions treatment benefits offered through the state's Part C programs are equally limited. Services are generally provided through local contracted treatment facilities and usually include bio-psychosocial assessment, psychiatric evaluation, psychological evaluation, individualized counseling, group and (in some areas) family support, and referral to detoxification.

7. Transportation

Indiana is without an organized transportation solution for HIV-positive individuals. However, a few small programs are available in select areas. First, various limited modes of transportation are provided through Medicaid for eligible individuals. These services are provided only for medically necessary travel. In the TGA, medical transportation is provided through the Bethlehem House and through two independent transportation providers. Also, each Part C clinical care site in the state has a small portion of funding available to assist with the transportation needs of their patients.

8. Housing

There are no statewide housing programs operated with Ryan White funds in Indiana. HOPWA is the only major program for HIV-positive persons seeking housing and utility assistance. The Indiana Housing and Community Development Authority receives funding from the Office of Housing and Urban Development to administer the program. It then distributes allocations to the regional HIV Care Coordination sites to provide rental or emergency housing assistance to low-income HIV-positive persons living in their area. (Recipients must be actively engaged in case management services to qualify.) The duration of the assistance can range from one to twelve months, based on the determination of the project sponsors. The 2008 allocation for the state (excluding central Indiana) is approximately \$837,000.

The Department of Metropolitan Development (Division of Community Development and Financial Services) administers the HOPWA grant for the City of Indianapolis. This grant serves the Indianapolis Metropolitan Statistical Area of central Indiana, which includes Marion, Boone, Hamilton, Hancock, Hendricks, Johnson, Madison, Morgan, and Shelby Counties. The City of Indianapolis, as the fiscal agent, apportions these funds among several service providers in the region to provide the same type of housing assistance and support services that are available through the HOPWA program in the rest of the state. The City's HOPWA allocation for 2008 is roughly equivalent to that for the entire rest of the state.

Resource Inventory

The continuum of care is naturally dependent on the availability of quality service providers. The current resource inventory (Attachment A) briefly describes the state's key provider(s) for each priority service need for each of the twelve defined service regions. The inventory also indicates how consumers can pay for the services and how many other viable options for the service are available. These entities or programs were identified by CHSPAC members from the respective regions based on direct and – in most cases – extensive experience with the noted providers.

Profile of Ryan White Providers

Indiana receives Part A, B, C, and F funds through the Ryan White legislation. Part A funds are awarded to the City of Indianapolis to serve the ten-county TGA surrounding Indianapolis. Part B funds are awarded to ISDH and administered by the Division. Part C funds are awarded to MCHD and the East Chicago Community Health Center. A third Part C provider, Matthew 25 AIDS Services, is based in Northern Kentucky but serves a section of Southern Indiana. Part F supports MATEC which is not considered to be a service provider. The vast majority of Ryan White funds are used to address the highest priority service needs: primary medical care and HIV-related medications.

1. Part A

MCHD is the administrator for the Part A funding within the Indianapolis TGA. The Part A program is administered by eight staff: a Director, Business Coordinator, Office Coordinator, Minority AIDS Initiative (MAI) Coordinator, MAI Community Liaison, MAI Health Education and Risk Reduction Coordinator, Planning Council Coordinator, and Quality Management Nurse.

The Director is responsible for overseeing all aspects of Indianapolis' Part A project's operations, including contract negotiations, developing operational procedures and programmatic policies, supervising staff and subcontractor performance, and ensuring fiscal and program-specific monitoring (specifically support services). The Director acts as a liaison with internal departments and external entities such as Federal, State, and local agencies and prepares and submits grants-related reports.

The Business Coordinator is responsible for internal reporting and fiscal monitoring with oversight from the Project Director. This position monitors data and prepares reports on fiscal data from service providers and ensures that required reports are received in a timely manner and contain allowable costs. Staff compiles utilization statistics, reviews monthly expenditures reports, processes contractor requests for reimbursement, and conducts quality checks.

The Office Coordinator is responsible for assisting the Director with a wide variety of clerical tasks that include: typing, faxing, copying, data input, filing, ordering supplies, coordination of office activities, answering telephone inquiries from employees as well as the public, coordination of employee travel/other requests, setting appointments, correspondence, and human resources for the Ryan White Program. This position also assists the Business Coordinator and Quality Management staff.

The MAI Coordinator works in collaboration with the Part A Director to ensure that planning, implementation, and administration of the MAI-funded services and activities are consistent with Part A programming. This position coordinates, implements, and monitors all aspects of the MAI program and is responsible for supervising the day-to-day activities of the MAI program, including quality management, and ensuring that program goals and objectives are fulfilled.

The MAI Community Liaison interacts with health care providers, conducts computer record searches, contacts clients by phone or in person, and documents the results of those inquiries. This position works with the MAI Coordinator and Part A Director to find eligible HIV-positive cases that are lost to care or not currently in care to provide clients a mechanism for entry into HIV care. This staff will identify people who are at risk for HIV infection and are unaware of their HIV status. If the client tests positive, they will assist the client in enrolling in treatment and supportive services. This position will also actively assist in referring clients to medical and non-medical case management.

The MAI Health Education and Risk Reduction Program Coordinator is responsible for developing and implementing services that educate clients with HIV about how to reduce the risk of secondary transmission. This includes the provision of information about medical and psychosocial support services and counseling to help clients with HIV improve their health status. The position will be responsible to increasing health education services that target communities of color, specifically African Americans and Hispanics who are living with HIV.

The Planning Council Coordinator is responsible for providing guidance and capacity building assistance to members of Indianapolis' TGA Part A planning body. This position facilitates development and attainment of the programmatic objectives, including fiscal oversight of planning council activities, coordination with Part B planning bodies, and providing administrative support to ensure the planning body completes its charge to assess the TGA's HIV service needs. This position also works with the planning body and program staff to establish priorities for allocation of funds, develops a comprehensive plan for the organization and delivery of HIV services that is compatible with existing state and local plans, and assesses the efficiency of MCHD to rapidly allocate funds to areas of greatest need.

The Quality Control Nurse is responsible for implementing a clinical management plan to establish that services are provided in accordance with Department of Health and Human Services (DHHS) guidelines and standards of care. This position will institute and monitor the indications that the Part A quality management committee has developed and those that will be used to evaluate outpatient and ambulatory services including the primary and secondary *HIV Core Clinical Performance Measures for Adults/Adolescent Clients*.

Implementation of the Part A program is administered through a collaboration of MCDH and a variety of community partners throughout the TGA. Through this program, persons living with HIV have access to a several Core Medical Services. These services include primary outpatient medical care, pharmaceuticals, insurance assistance, mental health services, substance abuse services, oral health services, early intervention services, medical case management (including drug adherence). Additionally, the program provides the following supportive services: non-medical case management, child care, emergency financial services, legal services, linguistic services, medical transportation, outreach services, psychosocial support, and short-term emergency housing.

2. Part B

Due to the manner in which the majority of services are delivered (via the insurance-based HIV Medical Services Program), ISDH and the Division continue to have direct responsibility for administering programs funded through Part B of the Ryan White Program in Indiana. Operational activities are managed by the Division's HIV Services section.

The Services Team consists of four Program Managers who report to one Services Coordinator who, in turn, reports to the Division Director. Each Program Manager oversees a specific HIV service component: Medical Services, Advisory Board Relations, Care Coordination, and Substance Abuse Services. (The two latter service components are not funded through Part B.) The team is augmented by necessary support staff. The Division consults with its advisory council for input on issues relative to Part B and state funds budgeted for HIV care programming. This advisory council consists of consumers and providers of HIV-related services, as well as members of the general public. The Indiana Department of Administration acts as the fiscal agent for all programs.

3. Part C

MCHD houses the state's largest Part C Program which serves Marion County and its eight contiguous counties. MCHD employs two Part C Program staff: a Part C Project Director and a Part C Business Coordinator. The Director monitors and coordinates the activities of subcontractors to ensure that the goals and objectives of the Part C Program are carried out in accordance with federal guidelines. The Business Coordinator is responsible for internal reporting and fiscal monitoring with oversight from the Program Director. This position monitors data and prepares reports on fiscal data from service providers and ensures that required reports are received in a timely manner contain allowable costs. Staff compiles utilization statistics, reviews monthly expenditures reports, processes contractor requests for reimbursement, and conducts quality checks.

In order to meet the needs of the community, the Part C Program provides early and easy access to primary medical care in neighborhoods most affected by HIV. Infected and at-risk populations can access services through neighborhood clinics and a hospital-based clinic. Once enrolled in MCHD's Part C program patients residing in the coverage area can access care at any affiliated provider regardless of the provider's geographic location.

The strength of Marion County's Part C program is derived from a coordinated system of care developed through collaborative relationships with six community health centers located in federally designated Medically Underserved Areas and Health Professional Shortage Areas, two hospital-based clinics, Marion County's largest AIDS Service Organization, and MCHD. This coordinated system of care provides access to quality primary care services and social services for our targeted population.

The Marion County Part C Program provides access to a variety of services, including primary medical care, infectious disease specialty services, and emergency pharmaceutical services. Specialty referrals can be made for dentistry, gynecology, obstetrics, cardiology, psychiatry, podiatry, gastroenterology, neurology, dermatology, and ophthalmology. The program can also provide access to medical and non-medical HIV case management and nutrition education on a fee for service basis. Comprehensive oral health care is offered through three main providers: Indiana University School of Dentistry, the Pecar Dental Clinic, and Citizens Health Center. Services available to all clients include an initial dental examination, two cleanings per year, preventive and restorative care, fillings, extractions and minor surgery.

Adherence education is a key component of routine medical visits and also of the general HIV counseling sessions provided to all newly diagnosed patients. The Part C Program funds adherence education and counseling on a fee for service basis at the Wishard Infectious Disease Clinic. Every patient who is initiated on ARV therapy (including those who change therapy) is counseled regarding medication doses, medication schedules, food restrictions, storage, common side effects, and drug resistance due to non-adherence. Adherence counseling is also scheduled outside of clinic times for patients requiring intensive educational sessions. This includes counseling regarding newer, complicated therapies, such as pegylated interferon for treatment of Hepatitis C, Fuzeon injection for HIV, or sessions for very complicated medication regimens that require more educational intervention.

Nutritional services are offered through a registered dietitian who provides individual and group nutrition education sessions and nutrition consultations on a fee for service basis. Nutrition consultants assess a client's nutrition status by reviewing anthropometric and laboratory data, medication side effects, diet history, food acquisition issues, and any lifestyle activities that may affect nutrition status (e.g., homelessness, substance abuse, etc.). Individual and group nutrition education sessions may focus on one or multiple topics. The nutritionist can assist the client in developing a personalized program by assessing the client's weight, eating

habits, prescribed medication and lifestyle. Bioelectrical Impedance Analysis is used to assess a client's possible wasting, as well as to quantify fat mass and lean body mass. Fat mass, lean body mass, body cell mass, and body mass index are tracked over time. Clients are then scheduled to return every six months for a follow-up evaluation.

Smaller in scope, the East Chicago Community Health Center (ECCHC) serves the northwestern portion of the state. It is a primary care and treatment program providing HIV-positive patients with access to the ECCHC providers. These providers include mid-level practitioners, internists, pediatricians, obstetricians, dentists, gynecologists, social workers, and benefits coordinators. ECCHC also supports a consumer advisory board. Patients receive primary care regardless of their ability to pay. ECCHC uses a sliding-fee schedule for patients; patients under 200% of FPL are not responsible for any portion of their medical care, laboratory, or medication expenses. All forms of insurance are accepted at ECCHC. It is currently an enrollment site for HIP and Hoosier Healthwise; it will be an enrollment site for Indiana Medicaid in the near future.

ECCHC participates in the 340B Drug Pricing program and purchases HIV medications for patients at a discount. Medications are dispensed at a local pharmacy, Fagen Pharmacy. HIV-positive patients receive referrals to the case management services provided through the Aliveness Project of Northwest Indiana. Mental and substance abuse services are available by referral to Tri-City Mental Health. The program also conducts free HIV testing and counseling and offers a support group for women with HIV.

A third Part C clinic is funded in Henderson, KY. The grantee operates a satellite clinic in Evansville, IN to serve portions of southern Indiana. Matthew 25 AIDS Services provides HIV services at no cost or according to a sliding-scale fee schedule. The clinic has the ability to bill third-party insurance including ICHIA, Medicare, Medicaid, and other private insurance. Their services include: primary HIV medical care, adherence counseling, comprehensive risk counseling, HIV testing, transportation assistance, and a food pantry. Specialty referrals can be made for substance abuse, dental, and psychiatric care.

4. Part F

Indiana is not a direct recipient of Part F funding. Indiana is served by MATEC which is located at the University of Illinois at Chicago. MATEC has a Local Performance Site (LPS) in Indiana housed at Indiana University Medical Center, a hospital of Clarian Health. The site is known as MATEC Indiana.

MATEC Indiana collaborates with all Ryan White Program grantees. MATEC Indiana is represented on CHSPAC in service to the Part B grantee and on the Part A Planning Council in service of the Part A and Part C grantees. MATEC Indiana takes information acquired from these council meetings to guide training initiatives throughout the state. This includes targeting and training clinicians in regions of Indiana that report limited access to medical, dental, and pharmaceutical providers.

Section 2 – OPTIMAL SYSTEM OF CARE

Recommendations for System Improvements

The Division has consistently recognized the original core services established by HRSA: Primary Medical Care, HIV-related Medications, Oral Health, Case Management, Mental Health Treatment, and Substance Abuse Treatment. The Division also has identified two additional services – Transportation and Housing – as crucial needs of the HIV-positive population. Together, these eight areas have formed the state's priority service needs as described in Section 1 of this document.

In 2006, HRSA issued a new list of allowable services, divided into thirteen “core medical services” and sixteen approved “support services.” The core medical services consist of: outpatient and ambulatory health services; ADAP treatments; local AIDS pharmaceutical assistance; oral health care; early intervention services; health insurance premiums and cost sharing assistance for low-income individuals; home health care; medical nutrition therapy; hospice services; home and community-based health services; mental health services; substance abuse outpatient care; and medical case management, including treatment adherence services. HRSA's support services include: non-medical case management; child care services; emergency financial assistance; food bank and home-delivered meals; health education and risk reduction efforts; housing; legal services; linguistic services; medical transportation services; outreach services; psychological support services; referral for health care and supportive services; rehabilitation services; respite care; treatment adherence counseling; and residential substance abuse treatment. The optimal continuum of care would address each of these areas of need by providing the most comprehensive services possible to the greatest number of high-need HIV-positive individuals.

While Indiana has successfully provided for some of these needs, significant barriers and limitations still exist. Advisory board members have developed the following recommendations to help service providers address the identified barriers to care for the under-served populations and to provide better quality services. All of the new core medical services, along with key support services, are included in these recommendations.

1. **Outpatient and Ambulatory Health Services** (corresponds to the Primary Medical Care service gaps and barriers)
 - a. The Part B grantee should work to expand its insurance continuation component to provide comprehensive health insurance coverage to the largest number of eligible individuals possible within its funding constraints.
 - b. The Part B grantee should continue collaborations with the Part A grantee to coordinate the payment of insurance premiums for the maximum number of enrollees possible.
 - c. The Part B grantee should continue collaborations with the HIV Care Coordination Program in an effort to identify the best resources for clients based on their eligibility characteristics.
 - d. The Part A, B, and C grantees should continue collaborations with the Part F grantee in an effort to identify additional infectious disease specialists in the state and to adequately educate other providers (including non-HIV specialists such as obstetricians, gynecologists, and mental health professionals) regarding HIV disease treatment.
 - e. The Part B grantee should continue to refine its HIV Medical Services Programs to minimize confusion for both consumers and providers in the areas of program utilization (i.e., how consumers can use the services) and reimbursement (i.e., how providers can bill for the services rendered). The Part B grantee should continue to work closely with training partners to ensure that case management staff members are provided training that addresses strategies to help improve consumer's experiences with the HIV Medical Services Program. The Part B grantee should ensure that its HIV Medical Services Program is marketed and explained to consumers in a culturally appropriate manner in order to minimize confusion and to maximize utilization among ethnically diverse populations
 - f. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure consumers' access to and adherence to treatment, despite barriers caused by poor health.
 - g. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure that persons in need are offered assistance in addressing needs related to health care system navigation.
 - h. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure that consumers are able to apply for private insurance and Medicaid with as few complications as possible. Special assistance should be provided to non-citizens to mitigate Immigration and Naturalization Service concerns related to applying for state programs.
 - i. The Part B grantee and its consumer advisory board should research the feasibility of conducting regional meetings to facilitate communication between providers and consumers.
 - j. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure that consumers are able to retain any State and Federal benefits for the maximum allowable duration. The Part B grantee should monitor the implications of current and future Social Security and Medicaid policies.

In this section...

- Recommendations for System Improvements
- Guiding Principals

- k. The Part B grantee and its consumer advisory board should research the feasibility of conducting regional meetings to address consumers' perceived mistrust of the medical establishment in some communities.
- l. The Part A, B, and C grantees should improve collaborations with the correctional system to guarantee that consumers experience an easy transition from one service component to the next.
- m. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure that case managers are well-versed in all aspects of Indiana Medicaid and are able to advise clients appropriately regarding the management of the Medicaid benefits.

2. AIDS Drug Assistance Program Treatments and

3. Local AIDS Pharmaceutical Assistance (corresponds to the HIV-related Medication service gaps and barriers)

- a. The Part B grantee should work to expand its insurance continuation component to provide comprehensive health insurance coverage to the largest number of eligible individuals possible within its funding constraints.
- b. The Part B grantee should continue its efforts to verify the eligibility of every HIV Medical Services Program enrollee to ensure that the program serves only those without access to other resources and to minimize the impact of the waiting list. The Part B grantee should continue collaborations with the Part A grantee to coordinate the payment of insurance premiums for the maximum number of enrollees possible.
- c. The Part B grantee should continue to provide ADAP during any waiting period for comprehensive health insurance coverage. This may include expanded ADAP rebate efforts.
- d. The Part B and its advisory board should work to develop an exhaustive listing of county and private hospitals in Indiana which offer indigent care.
- e. The Part A, B, and C grantees should continue to provide intensive training to its HIV Care Coordination grantees to ensure that case managers are able to assist consumers in the speedy navigation of the Medicaid enrollment process.
- f. The Part A, B, and C grantees should continue collaborations with other service providers to guarantee that emergency financial assistance funds for medications are available statewide to consumers without the necessary resources.
- g. The Part B grantee should continue to collaborate with its training partner to provide specialized training to the HIV Care Coordination providers to ensure that case managers are able to efficiently access the assistance available through manufacturer-sponsored indigent drug assistance programs.
- h. The Part F grantee should continue to include information regarding side effects, drug interactions, and strategies to increase adherence to prescribed regimens in its education of physicians and social service providers. The Part B grantee should continue collaborations with the HIV Care Coordination providers to assess consumers' barriers to adherence during the regular quarterly reviews.
- i. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure that case managers are well-versed in all aspects of Medicare Part D and are able to advise clients appropriately regarding the management of the Part D plan benefits.

4. Oral Health Care (corresponds to the Oral Health service gaps and barriers)

- a. The Part A and C grantees should continue to providing dental services are a wrap-around benefit to HIV Medical Services Program enrollees in central Indiana.
- b. The Part A and C grantees should work to ensure that area physicians, HIV Care Coordination grantees, and consumers are aware of the availability of their oral health services.
- c. The Part B grantee should encourage agencies to apply for Part C funds to improve access to appropriate dental services statewide.
- d. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure that case managers can effectively negotiate with dental providers for the acceptance of Medicaid as payment for their clients in need.
- e. The Part F grantee should increase the training opportunities targeted to dentists to expand the number of providers willing and qualified to serve those with HIV.
- f. The Part A, B, C, and F grantees should collaborate with the Division of Oral Health to determine if other options exist to address dental costs that not normally included in coverage formularies (such as extractions).
- g. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure that consumers are aware of the need for proper dental hygiene.
- h. The Part B grantee should continue to distribute the Division of Oral Health's Dental Clinic Directory to the HIV Care Coordination sites on a regular basis. The Part B grantee should also collaborate with the Division of Oral Health to offer educational materials and technical assistance to the HIV Care Coordination sites and their consumers.
- i. The Part A, B, and C providers should continue collaborations with other providers to guarantee that emergency financial assistance remains available for dental expenses.

5. **Early Intervention Services** (does not correspond to any service gaps or barriers)
 - a. The Marion County Part C program should continue to fund its Early Intervention Services (EIS) which provide HIV counseling, testing, and education activities at two community health centers (Citizens Health Center and HealthNet Community Health Center, Inc.).
 - b. The Part B grantee should continue to offer its early intervention services (through EIP) to ensure access to out-patient services during the period immediately preceding enrollment in the HIV Medical Services Program.
 - c. The Part B grantee should continue to require the Damien Center to locate an HIV Care Coordinator at the Bell Flower Clinic at least once per week to expedite referrals of newly diagnosed clients into case management services.
 - d. The Part A grantee should continue to explore the benefits of emergency room testing and referral (at Wishard Hospital) as a means to improve the linkages between testing, case management, and medical care; the Part B grantee should collaborate with ISDH prevention programs on similar initiatives.
6. **Health Insurance Premiums and Cost-Sharing Assistance For Low-Income Individuals** (relates to the Primary Medical Care and the HIV-related Medications service gaps and barriers)
 - a. The Part B grantee should work to expand its insurance continuation component to provide comprehensive health insurance coverage to the largest number of eligible individuals possible within its funding constraints.
 - b. The Part B grantee should continue its efforts to verify the eligibility of every HIV Medical Services Program enrollee to ensure that the program serves only those without access to other resources and to minimize the impact of the waiting list. The Part B grantee should continue collaborations with the Part A grantee to coordinate the payment of insurance premiums for the maximum number of enrollees possible.
 - c. The Part B grantee should continue to refine its HIV Medical Services Programs to minimize confusion for both consumers and providers in the areas of program utilization (i.e., how consumers can use the services) and reimbursement (i.e., how providers can bill for the services rendered). The Part B grantee should continue to work closely with training partners to ensure that case management staff members are provided training that addresses strategies to help improve consumer's experiences with the HIV Medical Services Program. The Part B grantee should ensure that its HIV Medical Services Program is marketed and explained to consumers in a culturally appropriate manner in order to minimize confusion and to maximize utilization among ethnically diverse populations.
7. **Home Health Care** (does not correspond to any service gaps or barriers)
 - a. Because home health care services are covered under the HIV Medical Services Program's insurance plan and Indiana Medicaid, the Part A, B, and C grantees are encouraged to focus attention and resources on other service areas.
8. **Medical Nutrition Therapy** (does not correspond to any service gaps or barriers)
 - a. The Marion County Part C grantees should continue offering its nutrition counseling service to eligible enrollees, utilizing a dietician placed in the HIV clinics who can provide information about nutritional supplements as well as overall nutritional health and exercise.
 - b. The Part B grantee should continue collaborations with the HIV Care Coordination Program to ensure that case managers understand that Medicaid will cover nutritional supplements with a physician's prescription and a pre-authorization.
 - c. The Part B grantee should continue to encourage the HIV Care Coordination grantees to use unobligated grant funds to stock limited supplies of supplements for emergency situations.
 - d. The Part A, B, and C grantees should continue collaborations with other service providers to guarantee that emergency financial assistance funds for nutritional supplements are available statewide to consumers without the necessary resources.
9. **Hospice Services** (does not correspond to any service gaps or barriers)
 - a. Because hospice services are covered under the HIV Medical Services Program's insurance plan and Indiana Medicaid, the Part A, B, and C grantees are encouraged to focus attention and resources on other service areas. In some areas, uninsured consumers can receive free hospice care.
10. **Home and Community-Based Health Services** (does not correspond to any service gaps or barriers)
 - a. Because home-based services are covered under the HIV Medical Services Program's insurance plan and Indiana Medicaid, the Part A, B, and C grantees are encouraged to focus attention and resources on other service areas.
 - b. The Part A, B, and C grantees should continue to identify and promote various monthly limited mobile health services to the community at varied sites during different days of the week. Community health fairs and health events offer screenings for varied possible health issues. Local free clinics and sliding fee scale clinics offer health services and programs to meet the needs of those on limited or no incomes.

11. Mental Health Services (corresponds to the Mental Health Treatment service gaps or barriers)

- a. The Part A, B, and C providers should continue collaborations with other providers to ensure that emergency financial assistance is available for mental health care.
- b. The Part B grantee should review the existing formulary for early intervention services to ascertain the feasibility of offering access to mental health services during the pre-existing condition period for the insurance component and beyond.
- c. The Part B grantee should encourage agencies to apply for Part C funds to improve access to appropriate mental health services statewide.
- d. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure that case managers can effectively negotiate with mental health providers for the acceptance of Medicaid as payment for their clients in need.
- e. The Part F grantee should increase the training opportunities targeted to mental health providers to expand the number of providers willing and qualified to serve those with HIV.
- f. The Part B grantee will continue to collaborate with the HIV Care Coordination Program to ensure that case managers can successfully assist consumers in overcoming the stigma associated with mental health treatment.

12. Substance Abuse Outpatient Care (corresponds to the Substance Abuse Treatment service gaps or barriers)

- a. The Part A, B, and C providers should continue collaborations with other providers to ensure that emergency financial assistance is available for addictions treatment.
- b. The Part B grantee should review the existing formulary for early intervention services to ascertain the feasibility of offering access to addictions treatment during the pre-existing condition period for the insurance component and beyond.
- c. The Part B grantee should encourage agencies to apply for Part C funds to improve access to appropriate addictions treatment statewide.
- d. The Part B grantee should continue to expand its Special Populations Support Program to ensure that each region in the state has access to the program's supportive care component.
- e. The Part A, B, and C grantees should continue collaborations with the HIV Care Coordination Program to ensure that case managers can effectively negotiate with substance abuse treatment facilities for the acceptance of Medicaid as payment for their clients in need. The Part B grantee and its Special Population Support Program should work with local substance abuse treatment facilities to ensure that HIV-positive patients receive priority when treatment barriers exist.
- f. The Part B grantee will continue to collaborate with the HIV Care Coordination Program to ensure that case managers can successfully assist consumers in overcoming the stigma associated with substance abuse treatment.
- g. The Part B grantee and its Special Populations Support Program should offer technical assistance regarding harm reduction techniques and philosophies to the local substance abuse treatment facilities.

13. Medical Case Management, including Treatment Adherence Services (corresponds to the Case Management service gaps or barriers)

- a. The Part B grantee should continue to work to mitigate the negative effect of continued funding cuts. This may include seeking additional sources of support or reducing funding in areas with less need.
- b. The Part A, B, and C grantees should support expanded HIV Care Coordination staffing and provide incentives to decrease staff turn-over despite increasing demands for service.
- c. In collaboration with its training partner, the Part B grantee should coordinate an intensive educational workshop for its case management staff. This workshop should provide uniform strategies to help staff manage the changing needs of the client population in a state with limited resources. It should be designed to help case managers empower their clients to make autonomous life decisions. It should also seek to re-energize and encourage the staff (possibly through the use of peer support and mentors).
- d. In collaboration with its training partner, the Part B grantee should continue to provide the most comprehensive skills-building trainings possible for its case management staff. Topics should include the management of clients with mental illness, substance abuse, and domestic abuse issues. Issues regarding women and families, homelessness, poverty, and financial management should also be continually addressed.
- e. In collaboration with its training partner, the Part B grantee should incorporate materials into its case management workshops which address the stress and frustrations inherent in working with a disabled and needy population.
- f. In addition to the cultural competencies that are incorporated into the current training program, the Part B grantee should consider offering (or reimbursing projects for the cost of) Spanish classes as a part of the standard curriculum.
- g. The Part B grantee should review available funding sources to determine if some funds could be allocated to support outreach efforts.

- h. The Part B grantee should encourage agencies to develop supportive service programs for their specialized populations (such as women and families, ethnic minorities, detainees).
- i. The Part B grantee should review the current complementary support programs to ascertain if the projects could be implemented uniformly on a statewide basis.
- j. The Part B grantee should continue to monitor sub-grantees to ensure that services are delivered without discrimination.
- k. The Part B grantee should continue to monitor and train sub-grantees to ensure that in-house training programs are uniform and thorough.
- l. The Part B grantee should continue its collaboration with the HIV Care Coordination Program to ensure that adequate mechanisms are in place to address after-hours client emergencies.
- m. The Part B grantee with its training partner should provide the necessary educational opportunities to ensure that the case management services being provided by the state satisfy the definition of “medical case management” as it would apply to a Part A, B, or C grantee.

14. Medical Transportation (corresponds to the Transportation service gaps or barriers)

- a. The Part A, B, and C grantees should continue to support service providers, particularly the HIV Care Coordination and other case management providers, as they explore innovative solutions to the transportation problem. The concept of a statewide transportation program and the expansion of the limited Part A medical transportation program should be assessed for feasibility.
- b. Where public transportation is available, the Part A, B, and C grantees should work to ensure that area agencies are aware of the available services (including Medicaid transportation services).
- c. The Part B grantee should research ways to provide transportation and other support services (particularly for marginalized groups such as the mentally ill, substance users, women with children, and detainees) through the existing HIV Care Coordination network.

15. Housing (corresponds to the Housing service gaps or barriers)

- a. The Part A, B, C, and Part F grantees should support and assist the Indiana Housing and Community Development Authority in its efforts to implement the recommendations described in the Indiana HIV/AIDS Housing Plan. The Part A, B, and C providers should continue collaborations with other providers to ensure that emergency financial assistance is available for housing-related costs not covered by HOPWA.
- b. The Part B grantee should research ways to improve access to adequate long-term housing assistance for low-income populations through the existing HIV Care Coordination network.
- c. The Part B grantee should continue to collaborate with the HIV Care Coordination Program to ensure that sites in each region are well connected with their local public housing providers and are able to efficiently navigate those systems.
- d. The Part B grantee should research ways to improve access to adequate housing assistance for marginalized groups such as the mentally ill, substance users, and ex-offenders through the existing HIV Care Coordination network.
- e. The Part B grantee should research ways to improve access to “acceptable” housing for the disabled and women with children through the existing HIV Care Coordination network and HOPWA program.
- f. The Part B grantee should continue to collaborate with the Indiana Housing and Community Development Authority to determine the feasibility of providing housing-specific training and technical assistance to all of the state’s HIV Care Coordination staff.

Guiding Principles

The Ryan White Program grantees and providers are committed to conscientiously addressing Indiana’s Statewide Coordinated Statement of Need and to improving the continuum of care. Providing the highest quality services in a cost-effective and equitable manner is a primary concern. Equally important is a commitment to serving those with the least resources, both in monetary terms and with respect to access to services.

Section 3 – SERVICE DELIVERY PLAN

Administrative Goals and Objectives

In order for Indiana to realize an improved system of care, achievement of the following administrative goals and objectives will be necessary. These goals are presented according to four major administrative areas: systems, planning, evaluation, and service. The administrative goals and objectives are designed to be long-term and to span the three-year period of this plan. They will be fully reviewed and updated every three years (i.e., for the period beginning 1 April 2012).

1. Systems Goal: To improve coordination between major Ryan White Program grantees.

- Objective 1. To maintain at least 60% of the full membership level on average for CHSPAC.
- Objective 2. To hold four quarterly meetings for Part A, B, C, and Part F grantees annually, with at least one meeting being held at each Part C grantee location.
- Objective 3. To annually review the eligibility requirements for all Part A, B, and C service components to ensure consistency.
- Objective 4. To annually review the benefit information for all Part A, B, and C service components to identify and eliminate any overlapping services.
- Objective 5. To coordinate the skills-building training efforts of the Part A, B, and C grantees with the advice of the Part F grantee.

2. Planning Goal: To maintain a dynamic Statewide Comprehensive Plan.

- Objective 1. To annually evaluate the necessity to conduct a new needs assessment and respond as appropriate.
- Objective 2. To obtain and incorporate updated epidemiological information into the Statewide Comprehensive Plan as necessary.
- Objective 3. To incorporate changes in available services and the service delivery system into the Statewide Comprehensive Plan as necessary.
- Objective 4. To create an annual revision of pertinent sections of the Statewide Comprehensive Plan, incorporating the Statewide Coordination Statement of Need annually.

3. Evaluation Goal: To document that funded interventions improve health outcomes for the target population.

- Objective 1. To complete the collection of service utilization data from ICHIA at least quarterly.
- Objective 2. To maintain database structures to archive and analyze all HIV Medical Services Program utilization information.
- Objective 3. To annually review benchmark health indicators against which to measure health outcomes.
- Objective 4. To annually compare current health and service utilization information for participants against the established benchmarks to evaluate the effectiveness of the HIV Medical Services Program.

4. Service Goal: To maintain HIV services statewide at current or expanded levels.

- Objective 1. To continue to request the maximum amount allowable under the ADAP 340B rebate program.
- Objective 2. To annually review all Part B budget items to determine if funds can be diverted from administrative costs to services.
- Objective 3. To document qualifying expenditures for HIV services at the level necessary to satisfy the annual federal funding match and Maintenance of Effort requirements.
- Objective 4. To support new Part C and D applications as funds are available.

Provision of Care Goals and Objectives

While the state's administrative goals and objectives are framed in terms of administrative activities, those for the provision of care are categorized according to the priority service needs. In some cases, single objectives apply to more than one goal and, therefore, are repeated. These are the goals and objectives of the Part B grantee and its advisory council. Other Ryan White Program Parts have developed their own unique goals which should be complementary to those listed here.

All of HRSA's new core medical services, along with key support services, are considered (though some – such as Home Health Care, Medical Nutrition Therapy, Hospice Services, and Home and Community-based Health Services – are not particularly relevant to the Part B grantee as they are not explicitly supported with Part B funds). Timeframes are indicated where applicable. In general, goals may be read as applying to the three-year plan period, while objectives may apply to individual fiscal year periods.

In this section...

- **Administrative Goals and Objectives**
- **Provision of Care Goals and Objectives**

1. Outpatient and Ambulatory Health Services

- a. Goal 1. To continue EIP as a transitory or “safety net” plan for coverage of HIV-related out-patient care for eligible HIV-positive persons without adequate health coverage.
 - Objective 1. To require all new EIP applicants to simultaneously submit applications for HIAP, ICHIA, Medicaid, and private insurance.
 - Objective 2. To screen all new EIP applicants for access to Part A and Marion County’s Part C services.
 - Objective 3. To transition all eligible EIP enrollees into HIAP for comprehensive insurance coverage within five months of the EIP effective date.
- b. Goal 2. To continue HIAP as a long-term solution for HIV-related out-patient care for eligible HIV-positive persons without adequate health coverage.
 - Objective 1. To require all new HIAP applicants to simultaneously submit applications for Medicaid.
 - Objective 2. To screen all new HIAP applicants for access to private insurance.
 - Objective 3. To recertify 100% of active enrollees for continued eligibility annually.
- c. Goal 3. To continue to provide efficient and cost-effective EIP and HIAP benefits for all eligible applicants.
 - Objective 1. To annually renew the contract for third-party administration of the EIP and HIAP benefits.
 - Objective 2. To ensure that the third-party administrator will maintain processing time at 15 working days or less for 90% of the claims.
 - Objective 3. To ensure that providers will receive payments from the third-party administrator for services rendered within 30 days of claim submission for 90% of the claims.
 - Objective 4. To ensure that providers are able to bill for EIP and HIAP services without undue complications by disseminating a “Provider Billing Fact Sheet” to explain the process.
- d. Goal 4. To promote client access and adherence to medical treatments.
 - Objective 1. To maintain the relationship between the Part B and Part F grantees in order to ensure that all providers seeking reimbursement under EIP and/or HIAP (at minimum) receive updated versions of the DHHS Guidelines and other information related to recommended HIV care.
 - Objective 2. To continue to offer access to information (including via the toll-free HIV Medical Services telephone line) and educational opportunities to providers, HIV Care Coordinators, the Indiana Department of Corrections, and consumers related to the HIV Medical Services Program and ICHIA including information regarding eligibility, enrollment, and the proper reimbursement procedures to assure successful access of services.
 - Objective 3. To continue to provide information to all existing HIV Care Coordinators designed to improve their skills for reinforcing the message to HIV-positive clients about the importance of remaining engaged in primary care.
- e. Goal 5. To continue to improve HIV medical services through diligent quality management.
 - Objective 1. To collect the full complement of utilization data for regular review and analysis.
 - Objective 2. To complete the Clinical Quality Management (CQM) report on at least an annual basis, documenting trends in patient health resulting from the services provided.
 - Objective 3. To coordinate CQM and contract compliance efforts with Parts A and C to the extent possible.
 - Objective 4. To complete the *HIV Core Clinical Performance Measurement* activities (Group 1) to ascertain the extent to which HIV medical services enrollees receive CD4 counts, medical visits, highly active antiretroviral (HAART) therapy, pneumocystis pneumonia (PCP) prophylaxis, and ARV therapy during pregnancy.
 - Objective 5. To document a 5% increase in ARV therapy compliance among HIV medical services enrollees.
- f. Goal 6. To continue to work to eliminate disparities in access to HIV medical services for disproportionately affected sub-populations and underserved communities.
 - Objective 1. To determine the extent of the disparity by annually creating the Unmet Need Estimate.
 - Objective 2. To annually analyze the Unmet Need Estimate results by subpopulation to determine the any disproportionate impact.
 - Objective 3. To increase the awareness of Part A, B, and C programs – in cooperation with HIV Care Coordination and HIV prevention programs – in disproportionately affected populations.
 - Objective 4. To monitor the demographic composition (by race, gender, and age) of the HIV medical services enrollees in comparison to the prevalence population.

- g. Goal 7. To efficiently manage and minimize the impact of any potential waiting list for the HIV Medical Services.
 - Objective 1. To consider a new Medicaid re-application process for active enrollees.
 - Objective 2. To consider a new Healthy Indiana Plan (HIP) application requirement for potential and existing enrollees.
 - Objective 3. To determine the impact of the current definition of household size and the consideration of spousal benefits.
 - Objective 4. To coordinate the management of the waiting list management with Part A grantee.

2. AIDS Drug Assistance Program Treatments and

3. Local AIDS Pharmaceutical Assistance

- a. Goal 1. To continue ADAP as a transitory or “safety net” plan for coverage of HIV-related prescription drugs for eligible HIV-positive persons without adequate health coverage.
 - Objective 1. To require all new ADAP applicants in to simultaneously submit applications for HIAP, ICHIA, Medicaid, and private insurance.
 - Objective 2. To transition all eligible ADAP enrollees into HIAP for comprehensive insurance coverage within four months of the ADAP effective date.
 - Objective 3. To provide to all ADAP-eligible applicants who are over the age of 65 and enrolled in a Medicare Part D plan a limited ADAP benefit designed to cover the Part D co-insurance and deductible expenses.
- b. Goal 2. To continue HIAP as a long-term solution for HIV-related pharmaceuticals for eligible HIV-positive persons without adequate health coverage.
 - Objective 1. To require all new HIAP applicants to simultaneously submit applications for Medicaid.
 - Objective 2. To screen all new HIAP applicants for access to private insurance.
 - Objective 3. To recertify each enrollee for continued eligibility annually.
- c. Goal 3. To continue to provide efficient and cost-effective pharmacy benefits management and claims processing for ADAP formulary drugs.
 - Objective 1. To annually renew the contract for third-party administration of the ADAP and HIAP benefits.
 - Objective 2. To ensure that the third-party administrator will maintain processing time at 15 working days or less for 90% of the claims.
 - Objective 3. To ensure that providers will receive payments from the third-party administrator for services rendered within 30 days of claim submission for 90% of the claims.
 - Objective 4. To ensure that providers are able to bill for ADAP and HIAP services without undue complications by developing a “Provider Billing Fact Sheet” to explain the process.
- d. Goal 4. To promote client adherence to ARV combination therapy regimens.
 - Objective 1. To maintain the relationship between the Part B and Part F grantees in order to ensure that all providers seeking reimbursement under EIP and/or HIAP (at minimum) receive updated versions of the DHHS Guidelines and other information related to recommended HIV therapies.
 - Objective 2. To continue to offer access to information (including via the toll-free HIV Medical Services telephone line) and educational opportunities to providers, HIV Care Coordinators, the Indiana Department of Corrections, and consumers related to the HIV Medical Services Program and ICHIA including information regarding eligibility, enrollment, and the proper reimbursement procedures to assure successful access of services.
 - Objective 3. To continue to provide information to all existing HIV Care Coordinators designed to improve their skills for reinforcing the message to HIV-positive clients about the importance of adherence to their ARV combination therapy regimens.
- e. Goal 5. To continue to improve HIV pharmaceutical utilization through diligent quality management.
 - Objective 1. To collect the full complement of utilization data for regular review and analysis.
 - Objective 2. To complete the CQM report on at least an annual basis, documenting trends in patient health resulting from the services provided.
 - Objective 3. To coordinate CQM and contract compliance efforts with Parts A and C to the extent possible.
- f. Goal 6. To continue to work to eliminate disparities in access to HIV pharmaceuticals for disproportionately affected sub-populations and underserved communities.
 - Objective 1. To determine the extent of the disparity by annually creating the Unmet Need Estimate.

- Objective 2. To annually analyze the Unmet Need Estimate results by subpopulation to determine the any disproportionate impact.
 - Objective 3. To increase the awareness of Part A, B, and C programs – in cooperation with HIV Care Coordination and HIV prevention programs – in disproportionately affected populations.
- g. Goal 7. To efficiently manage and minimize the impact of any potential waiting list for the HIV Medical Services.
- Objective 1. To consider a new Medicaid re-application process for active enrollees.
 - Objective 2. To consider a new Healthy Indiana Plan (HIP) application requirement for potential and existing enrollees.
 - Objective 3. To determine the impact of the current definition of household size and the consideration of spousal benefits.
 - Objective 4. To coordinate the management of the waiting list management with Part A grantee.
- 4. Oral Health Care**
- a. Goal 1. To maximize utilization of the existing oral health resources in the state.
- Objective 1. To ensure enrollment materials highlight the availability of the EIP dental services during the pre-existing condition period for insurance.
 - Objective 2. To continue distribution of the Division of Oral Health's directory of low-cost dental providers to all the HIV Care Coordination agencies in conjunction with an EIP services reminder notice.
 - Objective 3. To continue to identify HIV-friendly and EIP-friendly providers in the state's Resource Guide.
 - Objective 4. To work with potential funders of financial assistance to ensure that dental and other oral health expenses are eligible for reimbursement.
- b. Goal 2. To develop new oral health resources for HIV-positive persons in the state.
- Objective 1. To continually review the existing EIP formulary to ascertain the feasibility of expanding the range of dental services offered during the pre-existing condition period.
 - Objective 2. To collaborate with local community health centers to ascertain the extent of low-cost or free dental services provided.
 - Objective 3. To collaborate with local dental schools to ascertain if any additional low-cost or free dental services are available.
- 5. Early Intervention Services**
- a. Goal 1. To continue to work to eliminate disparities in access to early intervention services for disproportionately affected sub-populations and underserved communities.
- Objective 1. To determine the extent of the disparity by annually creating the Unmet Need Estimate.
 - Objective 2. To annually analyze the Unmet Need Estimate results by subpopulation to determine the any disproportionate impact.
 - Objective 3. To increase the awareness of Part A, B, and C programs – in cooperation with HIV Care Coordination and HIV prevention programs – in disproportionately affected populations.
- b. Goal 2. To work to coordinate the provision of services through HIV prevention, outreach, and early intervention projects.
- Objective 1. To ensure priority access to HIV Care Coordination for those with urgent medical needs.
 - Objective 2. To ensure priority access to HIV Care Coordination for those identified through Part A EIS as newly diagnosed or newly returning to care.
- 6. Health Insurance Premiums and Cost-Sharing Assistance For Low-Income Individuals**
- Because the Part B grantee utilizes an insurance mechanism to provide access to out-patient and ambulatory health care, to drug assistance program treatments, and to pharmaceutical assistance, its goals and objectives for "Health Insurance Premiums" are incorporated in the *Outpatient and Ambulatory Health Services*, *AIDS Drug Assistance Program Treatments*, and *Local AIDS Pharmaceutical Assistance* sections which appear in points 1-3 above.
- 7. Home Health Care**
- a. Goal 1. To determine the need for home health care services.
- Objective 1. To monitor utilization through the HIV Medical Services Program.
 - Objective 2. To identify resources in the state's Resource Guide for those ineligible for the HIV Medical Services Program.

8. Medical Nutrition Therapy

- a. Goal 1. To determine the need for medical nutritional therapy services.
 - Objective 1. To monitor utilization through the HIV Medical Services Program.
 - Objective 2. To identify resources in the state's Resource Guide for those ineligible for the HIV Medical Services Program.

9. Hospice Services

- a. Goal 1. To determine the need for hospice services.
 - Objective 1. To monitor utilization through the HIV Medical Services Program.
 - Objective 2. To identify resources in the state's Resource Guide for those ineligible for the HIV Medical Services Program.

10. Home and Community-Based Health Services

- a. Goal 1. To determine the need for home and community-based health services.
 - Objective 1. To monitor utilization through the HIV Medical Services Program.
 - Objective 2. To identify resources in the state's Resource Guide for those ineligible for the HIV Medical Services Program.

11. Mental Health Services

- a. Goal 1. To maximize utilization of the existing mental health resources in the state.
 - Objective 1. To ensure enrollment materials highlight the availability of the psychotropic drugs on the ADAP formulary during the pre-existing condition period for insurance and to include a new "Consumer Services Fact Sheet" explaining the other state and Ryan White programs that may be available.
 - Objective 2. To work with potential funders of financial assistance to ensure that mental health expenses are eligible for reimbursement.
 - Objective 3. To ensure (in conjunction with the Part F grantee) that the existing mental health providers are aware of the potential interaction of psychotropic medications with HIV drugs.
- b. Goal 2. To develop new mental health resources for HIV-positive persons in the state.
 - Objective 1. To annually review the existing EIP formulary to ascertain the feasibility of offering access to mental health services during the pre-existing condition period.

12. Substance Abuse Outpatient Care

- a. Goal 1. To maximize utilization of the existing addictions treatment resources in the state.
 - Objective 1. To ensure enrollment materials highlight the availability of the withdrawal management drugs on the ADAP formulary during the pre-existing condition period for insurance and to include a new "Consumer Services Fact Sheet" explaining the other state and Ryan White programs that may be available.
 - Objective 2. To work with potential funders of financial assistance to ensure that addictions treatment expenses are eligible for reimbursement.
 - Objective 3. To continue to promote the availability of SPSP supportive care to clinics, treatment facilities, and case management agencies throughout the state.
 - Objective 4. To ensure (in conjunction with the Part F grantee) that the existing substance abuse treatment providers are aware of the potential interaction of certain medications with HIV drugs.
- b. Goal 2. To develop new substance abuse treatment resources for HIV-positive persons in the state.
 - Objective 1. To annually review the existing EIP formulary to ascertain the feasibility of offering access to addictions treatment during the pre-existing condition period.

13. Medical Case Management, including Treatment Adherence Services

- a. Goal 1. To ensure concurrent enrollment in the HIV Care Coordination Program and other major HIV service components.
 - Objective 1. To continue to require that each new HIV Medical Services application originates from a funded HIV Care Coordination agency.
 - Objective 2. To continue to require that SPSP project staff members continually refer their enrollees back into the case management program for long-term care planning.
 - Objective 3. To continue collaborations between the Division, the Indiana Housing and Community Development Authority, and the Community Economic Development (Indianapolis) to ensure that HOPWA funds are distributed through the HIV Care Coordination network in an effort to improve housing stability.

- b. Goal 2. To improve the quality of the HIV Care Coordination Program in Indiana.
 - Objective 1. To continue collaborations between the Division and the training grantee to provide regular skills-building trainings for its case management staff on pertinent topics, such as mental illness, substance abuse, domestic violence, homelessness, poverty, and financial management.
 - Objective 2. To continue to perform annual program audits to review documentation, charting, and appropriateness of interventions.
 - Objective 3. To work toward more equitable case load distribution in an effort to improve the retention of quality case management staff.
 - Objective 4. To coordinate the state's HIV Care Coordination Program with any case management activities provided through the Part A and C grantees, including training, applications, and managing mutual clients.
 - Objective 5. To continue monitoring the HIV Care Coordination Program to ensure that quality vocational rehabilitation services are being offered regularly with clients.
 - Objective 6. To continue monitoring the HIV Care Coordination Program to ensure that quality adherence counseling is being conducted regularly with clients to improve CD4 and viral load counts.
 - Objective 7. To utilize recognized experts in adherence counseling to improve HIV Care Coordination staff skills in this area.
- c. Goal 3. To continue to work to eliminate disparities in access to case management services for disproportionately affected sub-populations and underserved communities.
 - Objective 1. To determine the extent of the disparity by annually creating the Unmet Need Estimate.
 - Objective 2. To annually analyze the Unmet Need Estimate results by subpopulation to determine the any disproportionate impact.
 - Objective 3. To increase the awareness of Part A, B, and C programs – in cooperation with HIV Care Coordination and HIV prevention programs – in disproportionately affected populations.
- d. Goal 4. To continue to identify individuals who know their HIV-positive status but are not in care and to work to engage them in the care system.
 - Objective 1. To collaborate with local emergency rooms to increase likelihood of HIV Care Coordination referrals.
 - Objective 2. To ensure that local HIV Care Coordination providers have promotional materials available at area physician offices.
 - Objective 3. To assess the feasibility of requiring the HIV Care Coordination providers to initiate a disease intervention referral for clients who have become “lost to care.”

14. Housing

- a. Goal 1. To maximize utilization of the existing housing resources in the state.
 - Objective 1. To compile and update annually a directory of regional low-cost housing options that can be distributed to case managers and incorporated into the state's Resource Guide.
 - Objective 2. To work with potential funders of financial assistance to ensure that housing and shelter-related expenses are eligible for reimbursement.
- b. Goal 2. To continue collaborations between the Division, Indiana Housing and Community Development Authority, and the Community Economic Development (Indianapolis).
 - Objective 1. To participate in the annual application review for HOPWA awards.
 - Objective 2. To work to ensure that HOPWA funds are distributed through the HIV Care Coordination network in an effort to improve housing stability.
 - Objective 3. To encourage the HIV Care Coordination Program grantees to work with other local, county, and statewide service providers through the regional housing *Continuum of Care* work groups (where applicable) to ensure that the HIV service provider perspective is represented as the problem of homelessness is addressed.
 - Objective 4. To encourage collaborations and partnerships between the HIV Care Coordination Program grantees and other housing service providers to ensure equal access to housing resources for the target population.
 - Objective 5. To continue the Division's participation in the statewide *Interagency Council to End Homelessness*.

15. Medical Transportation

- a. Goal 1. To maximize utilization of the existing transportation resources in the state.
 - Objective 1. To compile and annually update a directory of regional low-cost transportation options that can be distributed to case managers and incorporated into the state's Resource Guide.

- Objective 2. To work with potential funders of financial assistance to ensure that transportation expenses are eligible (including registration and insurance costs) for reimbursement.
 - Objective 3. To explore additional transportation resources that may be available regionally through Community Development Block Grants, Community Action Agencies, and Area Agencies on Aging.
- b. Goal 2. To develop new transportation resources for HIV-positive persons in the state.
- Objective 1. To annually research possible funding sources for developing any statewide transportation solution for HIV-positive individuals.
 - Objective 2. To identify programs which provide low-cost automobile registration and insurance for low-income consumers.

Section 4 – PROGRESS MONITORING

Implementation Plans

The major service component discussed in this plan, the HIV Medical Service Program, has been in continual operation for several years. The implementation of any changes to this or any other program discussed herein will occur according to the timeframes identified in the Service Delivery Plan (Section 3).

Monitoring Plans

The Division continually monitors its Part B contracts through the use of site visits, programmatic audits, utilization analysis, and monthly claim reviews. State-funded contracts (specifically for HIV Care Coordination) are also monitored through site visits, programmatic audits, and claim reviews; further, quarterly service provision is analyzed to determine compliance with quantitative guidelines.

Part B goals and objectives are monitored by the providers and consumers serving on the Evaluation Committee of the Part B advisory council; annually, progress toward goals will be evaluated and adjustments will be made as necessary. Objectives not achieved within the specified timeframe will be considered for continued relevance. Resources will be refocused as needed to address any outstanding issues, and timeframes will be adjusted accordingly. Over the three years covered by this plan, each yearly evaluation will be monitored to determine trends in progress.

Evaluation Plans

In accordance with Section 2618(b) of the Public Health Services (PHS) Act, the Part B grantee has established a CQM program to assess the extent to which HIV health services provided to patients are consistent with the most recent DHHS guidelines for the treatment of HIV disease and related opportunistic infections and, as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and the quality of HIV health services.

1. The HAB Perspective

The HIV/AIDS Bureau (HAB) has defined quality thusly: "Quality is the degree to which a health or social service meets or exceeds established professional standards and user expectations." In order to continuously improve systems of care for individuals and populations, HAB expects evaluations of the quality of care to consider:

- The quality of the inputs;
- The quality of the service delivery process; and
- The quality of outcomes.

Further, HAB has stated that quality management programs should recognize three primary purposes:

- To assist direct service medical providers funded through the Ryan White Program in assuring that funded services adhere to established HIV clinical practice standards and DHHS guidelines to the extent possible;
- To ensure that strategies for improvements to quality medical care include vital health-related supportive services in achieving appropriate access and adherence with HIV medical care; and
- To ensure that available demographic, clinical, and health care utilization information is used to monitor the spectrum of HIV related illnesses and trends in the local epidemic.

Finally, HAB believes that quality management plans should

- Be a systematic process with identified leadership, accountability, and dedicated resources available to the program;
- Use data and measurable outcomes to determine progress toward relevant, evidenced-based benchmarks;
- Focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement;
- Be a continuous process that is adaptive to change and that fits within the framework of other programmatic quality assurance and quality improvement activities; and
- Ensure that data collected is directed back into the quality improvement process to assure that goals are accomplished and that they are concurrent with improved outcomes.

In 2007, HAB issued its first group of *HIV Core Clinical Performance Measures for Adult/Adolescent Clients*. The group included five performance measures identified as essential in monitoring the health care outcomes of the patient population. The first five measures are:

- Percentage of clients with HIV infection who had two or more CD4 T-cell counts performed in the measurement year;
- Percentage of clients with AIDS who are prescribed HAART;
- Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year;

In this section...

- Implementation Plans
- Monitoring Plans
- Evaluation Plans

- Percentage of clients with HIV infection and a CD4 T-cell count below 200 who were prescribed PCP prophylaxis; and,
- Percentage of women with HIV infection who are prescribed ARV therapy.

2. The ISDH Clinical Quality Management Initiative Process

The mission, vision, and goals of the Division's CQM initiative precisely reflect the language of the PHS Act. The initiative strives to accurately assess the consistency of the Division's HIV medical services with the DHHS treatment guidelines and to ensure access to high quality health services for HIV-positive individuals throughout the state.

The Division's CQM initiative for its HIV Medical Services Program – which fully includes ADAP – consists of four distinct activities: establishment of health indicators, database analysis, provider education, and supportive service intervention. These activities are coordinated by the HIV Services Coordinator in cooperation with key internal staff, contractors, and external business partners.

a. Health Indicators

The Division had established immune system response (CD4 count) and virologic suppression (viral load count) trends as the primary health indicators for its 2005 CQM baseline report on HIV Medical Service Program enrollees. The same indicators were used for the 2006 and 2007 data analyses. Additionally, the Division has adopted HAB's first group of *HIV Core Clinical Performance Measures for Adult/Adolescent Clients* for the 2007 report. All reports relied on laboratory data obtained from the Division's OCDR which is considered to be the most comprehensive source for such information.

b. Database Analysis

Database analysis is conducted using the Agency Claims Administration Processing System (ACAPS) which was originally developed in 2003 as part of the agency's compliance plan for the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIV Medical Services Program utilization data is retrieved from the Division's third party administrator (TPA) and the insurance underwriter, imported into ACAPS at regular intervals, and reviewed by program staff. The Division uses the available utilization and OCDR data to create a variety of reports which attempt to describe the extent to which participants are receiving and responding to the quality care and treatment afforded by the program. This regular analysis is the core of the Division's CQM efforts, and the success of subsequent efforts to improve health outcomes are measured against its findings.

c. Provider Education

As the analysis is conducted, certain trends may indicate that provider education is warranted. However, due to the structure of the HIV Medical Services Program, no physicians or direct service providers are under contract with the Division; therefore, a strong partnership with the Part F grantee, MATEC, is crucial. At minimum, the Division provides MATEC with an annual listing of HIV-reporting physicians in the state (using surveillance data from OCDR) to ensure that they are in receipt of the most recent DHHS guidelines and updated treatment information. Should the database analysis identify providers who appear to be prescribing regimens that do not comply with these guidelines, additional training may be requested for those providers to ensure that the guidelines are followed in practice.

d. Support Service Intervention

As a complement to the provider education component, the Division also can ensure supportive service intervention by targeting specialized trainings to areas where clients appear to experience poor health outcomes (again based on the utilization review and other health indicators gathered during the application and recertification process). HIV Care Coordinators are currently trained to assist clients in achieving access to medical care and in adhering to the prescribed regimens. In geographic areas where the data imply that this is not happening, the Division can take direct action to improve the level of care and, thereby, the quality of life for clients.

The Division's TPA is required by contract to provide client-level utilization data, per service, to the Division on a routine basis. This includes data for any service covered by any component of the HIV Medical Services Program, including ADAP and insurance assistance. The information is received in a variety of electronic formats depending on the original data source. Details contained in the data include client identifiers, provider identifiers, dates of service and payment, NDC and CPT codes, service descriptions, co-payment and deductible amounts, and net cost. To date, the Division has successfully imported data for services dispensed as early as 2001.

Currently, demographic, health indication, and service utilization data are being collected from the HIV Medical Services Program applications, re-certification interview records, claims data collected by the TPA, and laboratory reports submitted to OCDR. The data will continue to be reviewed at least quarterly to identify any areas of concern. Areas requiring immediate attention will be studied by the Division and presented to the advisory council's ad hoc Medical Committee for its recommendations. Large-scale problems (such as barriers to physician access in rural areas) will be addressed in subsequent planning sessions where funding shifts can be considered. Smaller scale problems (such as suspected physician failure to adhere to DHHS treatment guidelines) can be addressed without delay through provider intervention and education with the assistance of MATEC. Overall, through this extensive review of data, the Division hopes to be able to closely monitor HIV-related illnesses and trends among the population being served and to document that those individuals receiving care through the program are experiencing positive health outcomes.

3. 2007 Quality Indicators

The data analysis which resulted in the 2007 edition of the CQM report focused on the four major health indicators for quality care used in previous CQM reports, one new CQM measure, and the five HAB performance measures. The Division's CQM indicators included timeliness, completeness, compliance, appropriateness, and positive health outcomes. HAB's performance indicators included clinical measures of CD4 count, HAART, medical visits, PCP prophylaxis, and ARV therapy for pregnant women.

a. Division CQM Measures

i. Timeliness

The analysis of timeliness considered the duration between the time the consumer submits an application and the time that services are available to be rendered. Specifically, it compared the application's signature date to the "document completion date" assigned by the Enrollment Specialist. The Division makes the assumption that the shorter the elapsed time, the more timely the service was rendered. This analysis was based on all new applications submitted in 2007. It does not take into account the wait list as the "document complete date" is assigned before the applicant can be placed on the list.

ii. Completeness

The analysis of completeness considered the discrepancy between the medical information requested on the application form and that received in the submitted application packet. Specifically, CD4 and viral load counts were reviewed. The Division makes the assumption that as the data set of health information is more complete, the analysis for health outcomes will be more accurate. This analysis was based on all new applications received in 2007.

iii. Compliance

The analysis of compliance ascertained the degree to which the enrollees engage the required case management services. Frequency of case management contact with all participating care sites in 2007 was reviewed. Due to the lack of electronic data from two providers (Wishard and LifeCare), enrollees seen at these sites were assigned to the mean frequency group (only one visit). The Division makes the assumption that as the frequency of case management contact increases, the chance for improved health outcomes over time improves. This analysis considered all HIAP enrollees in 2007 (defined as a member with a pre-ex or HIAP start date on or before 31 December 2007 and a HIAP end date on or after the same date or null).

iv. Appropriateness

The analysis of appropriateness compared the utilization trends to components of the DHHS guidelines to determine if adequate care has been provided. Particular attention was placed on evidence of ARV therapy, CD4 and viral load tests, and frequency of physician appointments. The Division makes the assumption that as adherence to the DHHS guidelines and best practice recommendations increases, health outcomes also will improve. This analysis also considered all HIAP enrollees in 2007 (as described above).

v. Health Outcomes

The analysis of health outcomes compared the frequency of specific HIV prescription fills – our best indicator of highly active ARV therapy adherence – to CD4 count trends. *(Note that in previous reports viral load data was used instead of CD4 count data).* The Division makes the assumption that as adherence improves, CD4 counts should increase. This analysis was based on all HIAP enrollees who have been receiving services continually from 1 January 2005 through 31 December 2007 (i.e., members with a pre-ex or HIAP start date on or before 1 January 2005 and a HIAP end date on or after

31 December 2007 or null) and who had evidence of at least two CD4 counts at least three months apart in the three-year report period according to the OCDR database.

Members of this cohort were placed into one of three tracks: Improving Health (with increased CD4 counts over the three-year period), Stable Health (with consistent CD4 counts over the period), and Declining Health (with decreased CD4 counts over the period). To determine the direction of the CD4 count trends the first count in the period was compared to the average of all counts within the period.

b. HAB HIV Core Clinical Performance Measures (Group 1)

i. HAB 1.1 – CD4 Cell Count

According to DHHS, the CD4 cell count plays a vital role in determining the staging of HIV disease and indicating the need for prophylaxis against opportunistic infections. It is commonly used in decisions regarding initiation or adjustment of ARV treatment. The most recent CD4 cell count is the strongest predictor of subsequent disease progression and survival, according to clinical trials and cohort studies data on patients receiving ARV therapy. This measure reflects important aspects of care that significantly impact survival and mortality. Data collection is currently feasible, and the measure has a strong evidence base supporting its use.

ii. HAB 1.2 – HAART

According to DHHS, randomized clinical trials provide strong evidence of improved survival and reduced disease progression by treating symptomatic patients and patients with CD4 cell counts under 200. This measure reflects important aspects of care that significantly impact survival, mortality, and transmission. Data collection is currently feasible, and the measure has a strong evidence base supporting its use.

iii. HAB 1.3 – Medical Visits

According to DHHS, clinicians should schedule routine monitoring visits at least every four months for all HIV-infected patients who are clinically stable. It is believed that greater experience among primary care physicians in the care of persons with AIDS improves survival. This measure reflects important aspects of care that significantly impact mortality. Data collection is currently feasible, and the measure has a strong evidence base supporting its use.

iv. HAB 1.4 – PCP Prophylaxis

According to DHHS, PCP is the most common opportunistic infection in HIV-positive people. Without treatment, over 85% of people with HIV eventually develop PCP. It is a major cause of mortality, yet it is almost entirely preventable and treatable. People with CD4 cell counts under 200 are at greatest risk of developing PCP. This measure reflects important aspects of care that significantly impact survival and mortality. Data collection is currently feasible, and the measure has a strong evidence base supporting its use.

v. HAB 1.5 – ARV Therapy for Pregnant Women

According to DHHS, treatment recommendations for pregnant women infected with HIV-1 have been based on the belief that therapies of known benefit to women should not be withheld during pregnancy unless there are known adverse effects on the mother, fetus, or infant and unless these adverse effects outweigh the benefit to the woman. ARV therapy can reduce perinatal HIV-1 transmission by nearly 70%. This measure reflects important aspects of care that significantly impact survival, mortality, and transmission. Data collection is currently feasible, and the measure has a strong evidence base supporting its use.

4. 2007 Goals and Results

In calendar year 2007, 303 new applications were received and 1317 enrollees received services. For the health outcomes analysis, the sample included 500 enrollees who had been receiving services for thirty-six continuous months and who had at least two CD4 tests recorded at least three months apart in the three-year period.

a. Division CQM Measures

i. Timeliness

The primary goal for timeliness is an average elapsed time of less than 30 days between application data and plan start date. In 2005, the Division experienced an average elapsed time of only 18 days. In 2006, the result rose to 21 days, but in 2007, the average time fell back to only 17 days.

ii. **Completeness**

The primary goal for completeness is an average CD4 and viral load report rate of 100% on initial application. In 2005, 2006, and 2007, these values were reported on all of the applications received and processed by the Division.

iii. **Compliance**

The primary goals for compliance are an HIV Care Coordination enrollment rate of 100% and an active HIV Care Coordination compliance rate (defined as four or more visits per year) of 85%. This goal was newly added to the 2007 analysis, and the data show that 94% of those receiving medical services were also enrolled in HIV Care Coordination and that 84% were actively compliant.

iv. **Appropriateness**

For 2005 and 2006, the primary goals for appropriateness were annual physician visit, CD4 test, and viral load test rates of 100% each. In 2005, 81% of enrollees had at least one physician visit. Nearly 50% had four or more visits with either a primary care physician or an infectious disease specialist. Surprisingly, however, only 30% had one or more CD4 tests, and only 26% had at least one viral load test within the twelve-month period.

In 2006, the percentage of enrollees with four or more physician visits improved to nearly 61%. Similarly, the percentage of those obtaining CD4 and viral load tests improved to 35% and 33%, respectively. Nevertheless, the continued discrepancy between frequency of visits and frequency of lab tests suggested that providers may not be uniformly following HIV treatment standards of care.

In 2007, the goals were adjusted to better reflect Indiana's Implementation Plan goals and HAB's clinical measurements. The goals are now stated as two or more physician visits, two or more CD4 tests, and two or more viral load tests for at least 75% of the enrollees. Results show that 68% of enrollees had at least two physician visits; 67% had at least two CD4 tests; and, 74% had at least two viral load tests. These results showed the previous discrepancy between visits and lab tests diminishing substantially in the period, perhaps due to improved electronic lab reporting to OCDR as well as some of the Division's interventions with providers described later under *Resultant Service Changes To Date*.

v. **Health Outcomes**

For the 2005 and 2006 reports, the primary goals for health outcomes were a quarterly triple-ARV fill rate of 100% for all health trend groups, a distribution of 100% of enrollees into either the Stable or Improving Health group, and 100% of the individual CD4 and viral load test results in the > 200 and undetectable ranges, respectively.

In 2005, 80% of the sample group was found to have filled triple-ARV prescriptions at least quarterly, regardless of trend of health. However, more than 13% of the sample group (also regardless of health trend) did not fill an ARV prescription, with 2% not filling any type of prescription at all. More than 85% of the sample had CD4 counts above 200, while only 40% had undetectable viral loads.

In 2006, the percentage of people who filled triple-ARV prescriptions on a quarterly basis fell to less than 70%, regardless of health trend. However, when those with just single or double ARV therapy are included in the analysis, the percentage rebounds to nearly 90%. The percentage of the sample group who did not fill any ARV prescriptions dropped to 7%, and every person in the sample filled at least one prescription in the year. The improvement in the prescription fill patterns did not correspond to evidence of improved patient health, however. In 2006, less than 80% of sample achieved CD4 counts above 200, and only 22% reported viral loads in the undetectable range.

In terms of group distribution, nearly 70% of the 2005 sample group was placed in either the Stable Health or Improving Health trend group. Among the individuals in the Declining Health group, more than 25% had either no drugs or no ARV drugs filled in 2005. This percentage was significantly smaller in the Stable Health and Improving Health groups (5% and 10% respectively).

For the 2006 report, the number of enrollees in the sample was determined to be 558, more than twice the size of the 2005 sample (which was only 203). The categorical distribution still favored the Improving and Stable Health groups (76.2% combined) with a Declining Health group percentage slightly lower than in 2005 (23.8% compared to 31.0%). Based on the utilization data, it appears that approximately 11% of Declining Health group received little or no ARV therapy within the time period (compared to 4% and 6% in the Improving and Stable Health groups).

For the 2007 report, the primary goals for health outcomes still included a distribution of 100% of enrollees into either the Stable or Improving Health group and 100% of the individual CD4 and viral load test results in the > 200 and undetectable ranges, respectively. The goal for ARV therapy was revised to account for confounding effect of 30-, 60-, and 90-day prescriptions on the utilization data analysis; the new goal for 2007 was 90% with evidence of 19-36 ARV “claim months” (months with at least one ARV drug dispensing) within the period.

In 2007, 80% of the 500-person sample group was found to have 19-36 ARV claims months recorded in the period, regardless of trend of health. Only 5% of the sample group did not fill an ARV prescription, with only one individual not filling any prescriptions at all. Nearly 89% of the sample had CD4 counts above 200, but only 23% had undetectable viral loads, based on the most recently reported counts for each. This result – seen consistently in all three CQM reports – may support the position that CD4 count improvement and viral suppression are not as closely connected as previously believed. It may also suggest that the 100% goal for undetectable viral loads is unrealistic and may need to be revised for future reports.

The categorical distribution in 2007 still favored the Improving and Stable Health groups (62% combined) but with the Declining Health group percentage rising from 24% in 2006 to 38%. Based on the utilization data, it appears that approximately 7% of Declining Health group received no ARV therapy within the time period (compared to 4% of the Improving Health group), suggesting again that providers may not be uniformly following HIV treatment standards of care.

Because participation in HIV Care Coordination is an eligibility criterion for the HIV Medical Services Program, the Division also has reviewed the extent to which this interaction has affected the appropriateness and health outcome goals. At baseline in 2005, the results were unclear. In some cases, case management appears to positively correlate to strong adherence: 94% of the enrollees who had four or more physician interactions were also active in case management. In other cases, the impact was not as positive: 77% of those who had declining health outcomes and who did not fill any ARV prescriptions in 2005 were also active in case management.

In the 2006 sample, 85% of the enrollees who had four or more physician visits were also case management clients and, for the Improving Health group, more than 90% of those with consistent ARV fill patterns received concurrent case management services. However, although 87% of the Improving and Stable Health groups were case managements clients, nearly as large a percentage of the Declining Health group were recipients of that service. Involvement in case management also seemed to have little effect on actual CD4 or viral load results, though the likelihood of the tests being conducted at all was better for those receiving case management.

Because it was recognized that many factors outside of a case manager's control can affect viral load test results and a client's adherence to treatment and therapy, this analysis was abandoned in the 2007 report. Instead, the frequency of case management contacts was simply compared to the frequency of medical visits, as this relationship appears to be the strongest in the historical data. (This comparison was not presented in the report's tables, but it was shown that frequency of case management contact continued to positively correlate with frequency of primary care visits.)

b. HAB HIV Core Clinical Performance Measures (Group 1)

i. HAB 1.1 – CD4 Cell Count

The national goal for CD4 cell counts is 90% with two or more counts performed at least three months apart in the calendar year 2007. The median goal is 63%. Based on full HIAP enrollees in CY 2007, excluding new enrollees from July through December and those who did not see a physician within the period, 55% of the sample group met the measurement criteria. Note that when using the Division's less restrictive inclusion guidelines – e.g., retaining new enrollees in the sample – the result is markedly better (67%, as described earlier).

ii. HAB 1.2 – HAART

The national goal for prescribed HAART is 90% in the report period for those with AIDS. The median goal is 100%. Based on full HIAP enrollees in CY 2007, excluding new enrollees from October through December, those without at least one CD4 count in history below 200, and those who did not see a physician within the period, 91% of the group met the measurement criteria.

iii. **HAB 1.3 – Medical Visits**

No national or median goals have been established for medical visits. However, based on full HIAP enrollees in CY 2007, excluding new enrollees from July through December, 39% of the sample group met the measurement criteria of two or more physician visits at least three months apart. Again, note that when using the Division's less restrictive inclusion criteria – e.g., retaining new enrollees in the sample – the result is significantly better (68%) and exceeds the goal established by Indiana's Part A program (65%).

iv. **HAB 1.4 – PCP Prophylaxis**

The national goal for PCP prophylaxis is 95% prescribed therapy in the report period for those with AIDS. The median goal is 94%. Based on full HIAP enrollees in CY 2007, excluding new enrollees from October through December, those without at least one CD4 count in history below 200, and those with such a count in history followed within three months by a subsequent count above 200, 49% of the group met the measurement criteria. This result was undoubtedly impacted by the manner in which "those with AIDS" was defined for the calculation, as it included anyone who had ever had a sustained CD4 count below 200. Future reports may focus instead on only those with a reported CD4 count below 200 in the measurement period.

v. **HAB 1.5 – ARV Therapy for Pregnant Women**

No national or median goals have been established for ARV therapy for pregnant women. However, based on full HIAP enrollees in CY 2007, excluding new enrollees from October through December, those without a pregnancy indicator, those without a pregnancy termination indicator, and those who had not seen a physician within the period, 100% of the group met the measurement criteria of prescribed ARV therapy for all pregnant HIV-positive women. This meets the goal established by Indiana's Part A program (100%).

5. Resultant Service Changes To Date

Initially upon reviewing the 2005 baseline report, the Division chose to focus on two specific elements to target for improvement: the frequency of out-patient primary care visits (particularly early in the enrollment period) and the incidence of CD4 and viral load testing. The 2005 data demonstrated that nearly a third of the service recipients had one or fewer physician encounters in the calendar year, and the 2006 data showed a similar pattern. The data from 2006 did indicate an increase in CD4 and viral load testing compared to 2005 (attributed largely to frequent communications with the HIV Care Coordination sites regarding the importance of these tests), but neither year approached the 100% goal.

In mid-2007, the Division initiated a number of activities to increase consumer awareness of the health advantages of routine medical visits and lab work. First, for a period of three months, each new enrollee received a welcome call from the HIV Medical Services Program Manager to help familiarize the member with the available services and to reinforce treatment plan adherence. Next, the annual recertification form was redesigned to prompt the HIV Care Coordinator to remind the consumer during the interview of the importance of obtaining and reviewing with their physician new CD4 and viral load test results at least annually. Finally, three mandatory refresher courses were conducted with the HIV Care Coordinators where the importance of full benefit utilization was stressed.

Also in 2007, the Division issued a letter to billing providers describing the program and its benefits as they relate to the DHHS guidelines. The letter underscored the availability of HIV-related services during the pre-existing condition exclusionary period for the insurance assistance component, a three-month window where utilization is traditionally suboptimal. Providers were also targeted with similar messages during an HIV update conference sponsored by MATEC in the fall of the year. Internally, with the participation of key advisory council members, the ADAP and early intervention formularies were exhaustively reviewed and revised. The goal of the revision was to ensure that all drugs and services considered essential in the guidelines were addressed in the formularies. The revised versions were issued in July.

As can be seen in the 2007 results, these efforts have helped to increase CD4 tests from 35% to 67% and viral load tests from 33% to 74%. Even under the stricter parameters, out-patient visit rates remained consistent. The Division has continued most of the activities initiated in 2007 throughout 2008 (including continued use of the revised recertification form, on-going refresher trainings, new enrollee welcome calls, and collaborations with MATEC) and hopes to see further improvements when the 2008 CQM report is issued in 2009. At a minimum, the Division expects to find a positive change in the frequency of out-patient visits and in the incidence of recommended laboratory testing. The 2008 report is scheduled to be presented to the advisory council in 2009 for feedback. At that time, the group will be asked to begin a process of formulating recommendations to

improve not only the design of the CQM report itself but also the service delivery system at large wherever deficiencies are found.

6. Planned Quality Activities

The overall goal of the CQM initiative in FY2009-2010 will continue to be the accurate assessment of the consistency of services provided through the HIV Medical Services Program with the DHHS guidelines for the treatment of HIV disease and related opportunistic infections. Through this process, the Division intends to improve adherence to the guidelines among providers and patients and to positively affect health outcomes.

While the 2005-2007 reports demonstrate that some of the goals are already being achieved, it remains clear that improvements are still possible. The Division will seek the guidance of its advisory bodies to determine what steps will be necessary to realize these improvements in 2009. The current CQM analysis process includes the first group of *HIV Core Clinical Performance Measures for Adult/Adolescent Clients* issued by HRSA. Future processes will begin to incorporate relevant elements from HRSA's second and third groups of performance measures.

Some additions to the existing report format are already under consideration. These include a comparison of the incidence of geno- and phenotype testing to indications of the start of new drug regimens. This may help the Division determine if physicians are incorporating evidence-based practices when managing treatment-experienced patients. Geno- and phenotype data may also explain instances in the analysis where adherence to medical visits does not appear to translate into improved CD4 and viral load results. Eliminating those on salvage therapy from the sample also may help to provide a clearer picture of the relationship between visits and lab improvements.

The Division is interested, as well, in analyzing the trends related to the initiation of ARV therapy to determine if physicians are beginning to adopt the recommendations for earlier treatment initiation (at CD4 counts of 350 rather than 200). Additionally, some overall design changes are under consideration for the 2008 report; these include developing *compliance tiers* (e.g., grouping those 90-100% compliant to medical visit, ARV fills, and lab test) that then can be compared to the various indicators (CD4 count, viral load, etc.). The Division is also considering reducing its goal for viral suppression to 75% of the sample based on evidence that CD4 improvements may not necessarily result in viral load decreases.

Finally, in collaboration with Indiana's Part A grantee, the Division is considering a limited series of qualitative chart reviews for all those in the report's Improving and Declining Health groupings whose utilization data did not indicate ARV therapy. Variables such as readiness to begin therapy, medication tolerability, substance use history, and mental health issues could be considered to help provide more insight into the reasons that treatment may have been delayed or interrupted for these individuals.

Beyond these CQM review activities, evaluation initiatives will be conducted by the consumer representatives serving on the Part B advisory council. Through surveys, local consumer meetings, and focus groups, these members will ascertain from the "ground level" how well the Part B services are meeting the needs of the affected population.

CONCLUSION

Indiana's Statewide Comprehensive Plan for FY2009-2012 provides a thorough description of the service delivery system for HIV care funded through Part B of the Ryan White Program and through allocations from the State of Indiana. It highlights the collaborations that the Division of HIV/STD has established with other HIV-related programs in the state to maintain a cohesive continuum of care. By incorporating the Statewide Coordinated Statement of Need, it also provides a description of the needs of persons living with HIV in the state and summarizes the perceived barriers to meeting those needs. The plan recommends a number of actions designed to overcome the identified barriers and summarizes the goals and objectives intended to address each priority service need.

Limitations

Due to the limitations of the funding and of the current health care delivery system in Indiana, some of the identified needs (such as dental and transportation services) are not exhaustively addressed in this Statewide Comprehensive Plan. The Division expects to continue its efforts to develop partnerships with other Ryan White Program grantees and other providers to ultimately reduce the impact of these needs on the HIV-positive population in the state.

The Statement of Need portion of the plan relies in part on the state's HIV/AIDS Needs Assessment Report, which was finalized and presented to the Division in February 2002. This report attempted to quantify needs based on direct feedback from consumers and providers of HIV-related services. Because of the subjective nature of the self-reported data from consumers, some areas of need may be under- or over-represented. Also, much of the information contained in the report was collected in 2000 and 2001 during a time of great transition for HIV services in Indiana, and many providers failed to respond. The report was not finalized until 2002. The report's information, and thus the needs identified, must be considered in this context.

Future Plans

This document is intended to be updated each year of the three-year plan period as the Division's response to the epidemic improves and expands. During the revision process, the Division will encourage increased involvement from consumers and members of its advisory council. The plan and its goals and objectives are scheduled for a complete revision in FY2012-2013.

ATTACHMENT A
2009 HIV SERVICES PRACTICAL RESOURCE GUIDE